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PROCEEDINGS

OF THE

MASSACHUSETTS

Homeopathic Medical Society.

1889 TO 1899.

VOLUME XII.

PUBLISHED BY THE COMMITTEE ON PUBLICATION.

BOSTON:
DANIEL GUNN & CO.,
31 HAWLEY STREET.
1899.

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INTRODUCTION.

In accordance with a vote of the Society, passed at the Annual Meeting, 1888, the publication of the Annual Volume of Transactions was discontinued, and arrangement made with the New England Medical Gazette for the publication in that journal of the various proceedings and the papers read at the meetings of the Society; and this arrangement has been carried out until the present time.

At the Annual Meeting, April, 1898, it was voted to resume the publication of the "Transactions," and that the first volume should comprise the proceedings of the Semi-Annual Meeting held in October, 1897, and of the Annual Meeting held in April, 1898.

At a meeting of the Executive Committee, held subsequently, it was deemed advisable for the better preservation of the Records that the volume should include a condensed report of proceedings at the various meetings held during the intervening ten years since the publication of the last previous volume of "Transactions."

Later it seemed to the Executive Committee expedient to bring the work up to date by enclosing in the same cover the transactions of the October, 1898 meeting, and of the Special Meeting held at Westboro in January, 1899, and also the revised By-Laws.

Thus the publication of the present volume has been

delayed somewhat beyond anticipation; but the Publication Committee take pride in at last presenting it to the Society in its completeness, confident that its abundant store of scientific articles and discussions contains a fund of information which will render it one of the most valuable volumes of "Transactions" published by the Society.

The importance of the Society is far greater than is apparent to the casual observer. While its work is accomplished without blare of trumpets, and in a quiet manner befitting the dignity of a scientific body, the results attained for the advancement of medical science in general, and the cause of Homeopathy in particular, are pronounced and far-reaching, and its influence for good is increasing year by year.

As illustrative of the character of the work constantly being done it may not be amiss to mention briefly a few of the more important events in the history of the Society during the last decade.

At a special meeting of the Executive Committee, held December 12, 1889, efforts were instituted toward securing State aid for the Massachusetts Homeopathic Hospital, and all are familiar with the magnificent result.

A notable event was the celebration of the Fiftieth Anniversary of the Society, by a banquet and appropriate literary exercises in Boston Music Hall, at which the governor, the mayor, the collector of port, and many other civic, literary, and social lights indicated by their presence and participation, the important place occupied in the Commonwealth by Homeopathy, and by our Society.

In 1891, a Committee was appointed to secure legislation looking to the restriction of the use of Arsenic in the various arts and manufactures. The following extract from the Committee's report will best indicate the work:—

"BOSTON, April 20, 1892.

To the Executive Committee of
The Mass. Homeopathic Medical Society.

GENTLEMEN:

The special committee appointed by your body last year for the purpose of securing from the State Legislature suitable restriction upon the indiscriminate use of arsenic in the arts, attended to the duties assigned them. They presented suitable petitions upon the subject from your body, in behalf of the State Society, and individual petitions from three hundred and sixty Homeopathic physicians.

Unexpectedly they found that there was a combination of the wall paper manufacturers of the country, including especially the large manufacturers of New York to resist any legislative action in the matter. They had retained as counsel Hon. John D. Long and two other able lawyers. Feeling that it was essential in order to properly present the matter to the Legislative Committee to obtain suitable counsel, the services of Hon. George S. Hale was secured. They found also that in the Mass. Medical Society, there were many who were willing to co-operate with the members of this Society in urging forward the movement; notably Doctors J. J. and C. P. Putnam, who secured petitions from thirteen hundred and twenty members of their society in behalf of our petition.

Several hearings were held which were stenographically reported, and have been published in a book of some three hundred and fifty pages.

The strongest evidence was presented showing the deleterious effect of the indiscriminate use of arsenic; a law was passed forbidding its use in certain cases and the sum of one thousand dollars was voted to enable the State Board of Health to make further investigations. The expense of all this amounted to a little over four hundred dollars. These bills have all been paid with the exception of one hundred and fifty dollars still due to the counsel.

Respectfully submitted,"

At the time of the threatened outbreak of Cholera, in the summer of 1892, our Society, at a special meeting called for the consideration of the subject, unanimously adopted the following resolutions:—

"*Whereas*, a malignant epidemic of Asiatic cholera has for some time been prevailing in certain parts of Europe, has gradually progressed to its western ports, and has now been brought across the Atlantic, and in view of the danger of its evading the most rigid quarantine and protective measures, and,

Whereas, while we heartily approve of all proper protective measures, we also believe Homeopathic treatment to afford the best and most effective therapeutic measure in this disease, and should be provided wherever demanded : that all proper measures should be taken to aid physicians in the treatment of patients to whom they may be called, and that the community should be instructed as to the best preventive measures to be adopted, therefore

Resolved, That the Massachusetts Homeopathic Medical Society appoint a Committee of five members, including the President, to prepare and issue, in the event of the disease becoming epidemic, to the Homeopathic physicians of this State a circular setting forth the symptoms and conditions exhibited in Asiatic Cholera, with the most approved remedies applicable thereto; also to prepare a circular for general distribution, describing the proper precautionary and preventive means to be adopted ; and also to take measures to secure proper hospitals and Homeopathic treatment in such cities or towns as may be invaded with this disease."

Had the dread scourge secured a foothold in this country, the Homeopathic physicians of our State would have been well prepared to do efficient work in establishing our therapeutic superiority.

Ever zealous for the establishment of Homeopathic institutions, and watchful over their welfare, our Society has supplemented its efforts in behalf of the Westboro Insane Hospital by successfully defending it against malignant and ungrounded attacks from those inimical to our cause.

In 1896, after thorough investigation of every detail of management and careful examination of statistics, a special committee presented at a Legislative hearing incontrovertible evidence highly favorable to the continuance of the treatment of the curably insane by the methods used at Westboro, especially the employment of remedies Homeopathically administered.

The work done by our Society in this matter not only served to render our Institution at Westboro more secure in public favor, but was largely influential in bringing about

the re-organization of the State Board of Lunacy and Charity.

When State Registration in Medicine became a law, our Society was active in securing proper Homeopathic representation upon the Board, and certificates were issued to our members without question.

This brief mention of a few of the more important incidents in our recent history will serve to give an idea of the many and varied interests ably served by the Massachusetts Homeopathic Medical Society.

Ever alert to promote the welfare, not only of Homeopathy, but of its individual members, the Society deserves and should receive the hearty endorsement of every Homeopathic physician in the State; and it is earnestly hoped that in the next decade its membership may be at least doubled, and its influence correspondingly increased.

FRANK C. RICHARDSON,
Secretary.

January 1, 1899.

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PROCEEDINGS

OF THE

FORTY-NINTH ANNUAL MEETING

APRIL 10–11, 1889.

The annual meeting of the Massachusetts Homeopathic Medical Society was held at Steinert Hall, Boston, Wednesday, April 10, and at Westboro', Thursday, April 11, 1889.

FIRST DAY'S SESSION.

The meeting was called to order at 1 P. M. by the Vice-President, James Hedenberg, M. D., Medford, the President, J. W. Hayward, M. D., Taunton, having suffered a painful accident, which made it impossible for him to be present.

TREASURER'S REPORT.

H. C. Clapp, M. D., Treasurer, presented the following report:

Massachusetts Homeopathic Medical Society:—

TREASURER'S REPORT, 1888-9.

CR.

Cash balance in Treasury, April 11, 1888 . . .	$954.79	
Collected during the year	950.40	
		$1,905.19

DR.

Expenses during the year	$1,065.69	
Cash balance in Treasury, April 10, 1889 . . .	839.50	
		$1,905.19

H. C. CLAPP, M. D., *Treasurer.*

AUDITOR'S REPORT.

I have this day examined the books and accounts of H. C. Clapp, Treasurer, and find them properly kept, correctly cast, and vouchers for all disbursements.

A. J. FRENCH, M. D., *Auditor.*

NEW MEMBERS.

Boston, April 10, 1889.

The following candidates were elected to membership:

John W. Bosworth, M. D., Roslindale; Charles L. Seip, M. D., New Bedford; Herbert A. Chase, M. D., Cambridgeport.

The chair then announced that the polls would be open from 2 P. M. to 6 P. M. for the election of officers for the ensuing year, and appointed the following tellers to receive, sort, and count ballots: F. A. Gardner, M. D., O. W. Roberts, M. D., Lamson Allen, M. D.

REPORT OF THE COMMITTEE ON CLINICAL MEDICINE.

H. E. SPALDING, M. D., *Chairman.*

Subject — "Typhoid Fever."

I. Statistics. H. E. Spalding, M. D.
II. History. J. K. Culver, M. D.
III. Aetiology and Diagnosis. B. T. Church, M. D.
IV. Pathology, Morbid Anatomy and Concomitant Diseases. H. M. Hunter, M. D.
V. Treatment, Medicinal and Dietetic. J. J. Shaw, M. D.
VI. Sequelæ. D. B. Whittier, M. D.
VII. Purpura Hæmorrhagica. A Clinical Study. Prosper Bender, M. D.

DISCUSSION.

Dr. H. L. Chase spoke of the account furnished by him to Dr. Spalding and called attention to cases of typhoid, caused by the contamination of milk by water from a well in the country. Has had very few cases of true typhoid, but very many cases closely simulating it. Believes that typhoid originates always from a specific germ, but holds that many so-called cases of typhoid are really cases of septic fever caused by filth.

Dr. E. U. Jones said that, in his capacity of health officer, he had found that a larger proportion of cases reported as such, were not typhoid at all. Believes that in those hepatic forms of enteric fever, with foul, loose discharges coming on in the second week, baptisia will be found of great benefit. Also wished to speak of this remedy as a true antiseptic in erysipelas.

Dr. N. R. Morse protests against the supposed usefulness of a board of health, and the publication of the numbers of cases of typhoid or other contagious diseases, saying that, in his opinion, a knowledge of the presence of such diseases demoralizes the people and thus increases the danger of contagion.

REPORT OF THE COMMITTEE ON OBSTETRICS.

G. R. SOUTHWICK, M. D., *Chairman.*

I. Dystocia, from faulty condition of soft parts. Walter Wesselhoeft, M. D.
II. Same Subject. Geo. H. Earl, M. D.
III. Third Stage of Labor. Sarah E. Sherman, M. D.
IV. Case of Hyper-emesis of Pregnancy. Emily Bruce, M. D.
V. Case of Triplets. G. A. Slocomb, M. D.

DISCUSSION.

Prof. J. C Wood, of Ann Arbor, said that in conducting a case of labor the accoucheur should ever keep in mind the processes of nature. He should remember the normal condition of the cervix, and that dystocia is only a relative term. If we have dilatability and retractibility with interval of repose we have a natural condition. Dystocia may be due to too persistent contractility, and Prof. Wood has here found anæsthetics and anodynes of great use. Prefers in early stages to use chloroform where there is undue contractility; also uses chloral hydrat. grs. xx in water, and finds it relaxes rigid cervix. He fully endorses hot water applications. In rigid perineum, with feeble pains, uses anæsthesia, and in this condition cannot urge too strongly the use of hot applications; has found a solution of lobelia in hot water of great value.

Dr. C. E. Fisher, of Chicago, formerly of Texas, wished to hear from the homoepathic treatment of dystocia. He thought rigid os to be due to reflex irritability and has relieved it by cham., bell., gels., etc. Has used only hot water to relax the perineum.

Dr. Fisher spoke with delightful enthusiasm of the opportunity of homeopathy in the South, and of the need there of young graduates to fill the many good openings.

Dr. A. M. Cushing related cases illustrating the successful use of amyl nitrite instead of chloroform or ether.

Dr. G. H. Earl explained that his paper was confined to the mechanical management of dystocia and did not wish the omission of remedies to be construed as a disbelief in their efficacy. In regard to the application of heat he preferred the hot douche to the hot bath.

Prof. Wood wished to state that his faith in the indicated remedy is great, he did not ignore internal medication, but in his

remarks was rather considering expedients. Thought that chloroform should not be used until there is some dilatation of the cervix. At the outset of labor an anæsthetic is useless.

Dr. Newton spoke of the successful use, by the Eclectic School, of lobelia, bell., and cimicif. for these conditions. Dr. Newton thinks it much better to have a ruptured perineum than an overstretched one.

REPORT OF COMMITTEE ON OPHTHALMOLOGY AND OTOLOGY.

H. P. BELLOWS, M. D., *Chairman.*

Dr. Bellows presented a most interesting paper entitled, "Kali Mur. in Aural Diseases."

REPORT OF COMMITTEE ON ELECTRO-THERAPEUTICS.

W. H. WHITE, M. D., *Chairman.*

I. Treatment of Membranous Dysmenorrhœa with Electricity. C E. Gary, M. D.

II. Treatment of Chronic Metritis. W. H. White, M. D.

DISCUSSION.

Dr. L. A. Phillips, referring to Dr. White's paper, asked if electricity cured the malposition as well as the enlargement. Dr. White replied that it did in the case spoken of. Dr. Newton inquired if Dr. White really reduced the body of the uterus by his treatment. Dr. White replied in the affirmative, and in answer to question by Dr. Utley, stated that he favored short sittings often repeated, preferring sittings of three minutes duration to longer ones; also spoke of the importance of having the patient remain quiet for some time after an application of electricity.

Dr. J. K. Warren spoke of the importance of specifying the strength of the current and the length of the sittings. The number of cells does not indicate anything definite.

The report of the necrologist, E. U. Jones, M. D., was read by the secretary, and contained eloquent tribute to the memory of Drs. Charles H Walker, Lafayette Macfarland, John A. Burpee, Elam C. Knight, Henry B. Clarke, G. Felix Matthes, and Ellen S. Getchell.

The election of officers resulted as follows:

President, H. A. Houghton, M. D., Charlestown.

Vice-presidents, James Hedenberg, M. D., Medford; F. B. Percy, M. D., Brookline.

Corresponding secretary, J. Wilkinson Clapp, M. D., Brookline.
Recording secretary, F. C. Richardson, M. D., East Boston.
Treasurer, H. C. Clapp, M. D., Boston.
Librarian, A. J. Baker, M. D., Boston.
Censors, J. W. Hayward, M. D., Taunton; A. J. French, M. D., Lawrence; E. P. Colby, M. D., Wakefield; W. Wesselhoeft, M. D., Cambridge; D. B. Whittier, M. D., Fitchburg.

Dr. H. C. Clapp, chairman of the committee on Transactions appointed by the Executive Committee, stated that the committee's report was to the effect that, as the society's expense had, through various causes, proved for the last four years much in excess of its income, retrenchment in some direction was an evident necessity. The bill for the publication of the transactions, in the bulky volume in which they had hitherto appeared, was an exceedingly heavy one. Publication of the papers presented to the society and approved by the publication committee, in a single magazine with which contract could be made, would be a vast economy, and entail no practical loss to the society.

After considerable discussion, the following motion was carried unanimously:

Moved, "That the report be accepted, and the committee be requested to make the best arrangement possible for the publication, monthly, in some medical journal, of the transactions of this society."

Dr. L. A. Phillips presented in writing the following amendment to By-law No. 4, striking out the clause, "and shall also furnish a list of two candidates for each office of the society for the ensuing year."

After the transaction of routine business the meeting adjourned.

Supper for members of the society and their guests was served at Hotel Thorndike at 8 P. M. Nearly one hundred ladies and gentlemen sat down at the tables. Among these, as guests, were Dr. Henry M. Paine of Albany, Prof. James C. Wood of Ann Arbor, Mich., Dr. C. E. Fisher of Chicago, and Dr. S. H. Vehslage of New York City.

The company having been called to order, Dr. J. Heber Smith, as toastmaster, announced as the first toast:

"DR. SAMUEL HAHNEMANN."

"On the tenth day of April, in 1755, at Meissen, in Saxony, was born the founder of our school of practice. One hundred and

thirty-four years ago he first drew vital breath in the humble home of a porcelain painter, who was destined to reform medicine, and on this anniversary of his birth we pay the best tribute of respect to his memory in a thoughtful and just estimate of his influence.

"I call Dr. Conrad Wesselhoeft, author of the most perfect translation of Hahnemann's Organon, and for the past sixteen years the painstaking and discriminating expounder of the principles of homeopathy to students, as therein enunciated."

Dr. Conrad Wesselhoeft made an able response.

The next toast was one general to the "Profession of Medicine."

"The homeopathists of Massachusetts offer greetings to all doctors of medicine; but behind no closed doors, nor under cover of any flag-of-truce, reiterate their principles, to which they have pledged their lifelong devotion."

Dr. Walter Wesselhoeft ably responded.

Dr. I. T. Talbot then responded to the following sentiment: "Law and Medicine."

"Solidarity the Need of the Hour in Medicine."

"Consolidation of interests and responsibilities among physicians, without regard to medical belief or sects, the only way open to the commanding of public esteem, and the ultimate protection of the people from inferior medical and surgical service."

Other toasts included "The Physician, a Public Teacher as well as a Practitioner," responded to by Dr. Edward L. Mellus; "Women in Medicine," by Dr. Adeline B. Church of Winchester; "Homeopathic Surgeons," by Dr. Alonzo Boothby.

Prof. Wood, Dr. Fisher and other gentlemen also addressed the gathering.

Shortly before 11 o'clock the post-prandial exercises were brought to a close.

SECOND DAY'S SESSION.

The second day's session was held at Westboro Insane Hospital, Thursday, April 11, 1889, about seventy members of the society being present. Lunch, furnished by the society, was served at 1 P. M., and after inspecting the hospital the members assembled in the chapel and listened to the following

REPORT OF THE COMMITTEE ON INSANITY AND NERVOUS DISEASES.

E. P. COLBY, M. D., *Chairman.*

I. Paranoia. George S. Adams, M. D.
II. General Paresis. Amos J. Givens, M. D.
III. Acute Mania. Dr. Wiswell.
IV. Acute Melancholia and Feeding. Dr. Nivison.
V. Cerebral Surgery and Localization. N. Emmons Paine, M. D.

These papers were all illustrated by typical cases selected from the wards of the hospital, which added greatly to the interest and value of the report. During the session one side of the room was screened off and devoted to pathological work under the charge of George O. Welch, M. D., who presented and explained many interesting and instructive microscopical specimens.

At 4.49 P. M. the train was taken for Boston, where the members arrived at 6 P. M., well satisfied with the forty-ninth annual meeting of the Massachusetts Homeopathic Medical Society.

PROCEEDINGS

OF THE

FORTY-NINTH SEMI-ANNUAL MEETING.

OCTOBER 9, 1889.

The semi-annual meeting of the Massachusetts Homeopathic Medical Society, was held at Steinert Hall, Boston, Wednesday, Oct. 9, 1889.

The meeting was called to order by the President, H. A. Houghton, M. D., of Charlestown, at 10.30 A. M.

After the reading and approval of the records of the Annual Meeting, the following candidates were elected to membership.

Frederick W. Elliott, M. D., Boston; Charles H. Thomas, M. D., Cambridge; Virginia T. Smith, M. D., Boston; Clara C. Austin-Leach, M. D., Boston; F. C. L. Pfefferkorn, M. D., Lawrence.

REPORT OF THE COMMITTEE ON GYNÆCOLOGY.

I. Gonorrhœal Infection in Women. L. A. Phillips, M. D.
II. Electrolysis in Pelvic Tumors. Wm. P. Defriez, M. D.
III. Remarks on Progress in Gynæcology. Alonzo Boothby, M. D.

DISCUSSION.

Dr. D. B. Whittier, speaking of Dr. Phillips' paper, wished to endorse what had been said in regard to the necessity of physicians cautioning patients against communicating gonorrhœa, and instructing them as to its extremely infectious character.

Dr. L. D. Packard has not found cases of gonorrhœa in women to be productive of such disastrous results as claimed by Dr. Phillips. Has seen very many cases, but no disastrous after-effects.

Dr. H. L. Chase agrees with Dr Packard. Has not met the extremely disastrous effects spoken of, yet considers it a very seri-

ous disease, requiring utmost care. Has never been able to find the gonnoccus in females.

Dr. J. W. Whidden, of Portland, Maine, is convinced from his experience that latent gonorrhœa is responsible for many distressing pelvic conditions, as stated by Dr. Phillips. Wished to ask if women suffering with these conditions are capable of communicating gonorrhœa to the male.

Dr. Phillips considers infection rare from the latent form existing chiefly in cervical canal and above.

Dr. W. H. Tobey thinks the danger from gonorrhœal infection in women greatly over-estimated by Dr. Phillips; does not believe in latent gonorrhœa, and does not consider gonorrhœal inflammation worse than any other inflammation; therefore just as capable of permanent cure.

Dr. J. H. Sherman is surprised to find that gonorrhœa is so formidable a disease; has had considerable experience extending over many years, and has never so considered it. Has met with but one instance of disastrous after-effect.

Dr. Alonzo Foothby is aware that it is often difficult to prove a connection between gonorrhœa and the many pelvic disorders supposed to result from it; yet the absence of other causes, and the fact that in a large number of cases the husband has at some time had gonorrhœa, creates the suspicion that this disease may have been the origin.

Dr. Phillips, in reply to a question if it is true that gonorrhœal discharge in women gives acid re-action, and leucorrhœal discharge, alkaline, said that investigators have decided this test entirely unreliable. In regard to the dangers from gonorrhœal infection in women, the opinion of such men as Comstock, Runnels, and Ludlam, outweighs that of those of less experience, and they concur in the opinion of its severity and disastrous results in women.

REPORT OF THE COMMITTEE ON OPHTHALMOLOGY AND OTOLOGY.

I. A case of Convergent Strabismus dependent upon a high degree of hypermetropic astigmatism.

Dr. J. C. Gannett, of Yarmouth, Maine, and Dr. J. W. Whidden, of Portland, Maine, were received as delegates from the Maine Homeopathic Medical Society, and invited to participate in the deliberations of the Society.

At 1 P. M. the meeting adjourned for lunch, which was served at the Hotel Thorndike and gave general satisfaction.

Before returning to the hall, N. W. Emerson, M. D., delivered an eloquent oration, replete with lofty sentiments, appealing to the finer feelings, and pointing the profession to a higher plane of thought and action.

AFTERNOON SESSION.

REPORT OF THE COMMITTEE ON MATERIA MEDICA.

I. On the Methods of Critical Analysis of Materia Medica. By C. Wesselhœft, M. D.

II–III. Critical Analysis of Drug Provings. By Albert Pick and F. Pritchard, M. D., with Introductory Remarks by Conrad Wesselhœft, M. D.

Podophyllum.

Arum triphyllum.

Dr. Wesselhœft explained fully the process and utility of "Chart-making," and offered the summaries of Mr. Pick and Dr. Pritchard as examples of the result to be obtained.

DISCUSSION.

Dr. T. M. Hunter considered the plan proposed an excellent one theoretically, but impracticable on account of the discrepancies existing in the works of our different compilers.

Dr. Wesselhœft considers this objection by no means insurmountable. The writings of our earlier compilers might certainly give rise to grave perplexity, and he regretted that these works, which had so long outlived their usefulness, should still be worshipped as authorities. But a short cut has been afforded us by a few clear-headed scientific men.

T. F. Allen and Richard Hughes have given us classic works which are sufficient for our purpose, and will be standard works, not only for homeopathists but for the entire medical profession.

REPORT OF THE COMMITTEE ON SURGERY.

I. A Case of Gangrene. James Utley, M. D.
II. A Review of Abdominal Surgery, with a Report of One Hundred and Twelve Consecutive Cases. Horace Packard, M. D.
III. A Case of Congenital Equino Varus, with a New Splint. Geo. H. Earle, M. D.
IV. Congenital Phimosis: Its Rational Treatment. N. W. Emerson, M. D.

These papers were read and briefly discussed.

Dr. J. P. Sutherland exhibited a modification of the Levis splint, allowing of a circulation of air to the part enclosed.

The following were appointed a committee to consider the proposed amendment of By-law No. 4: L. A. Phillips, M. D.; I. T. Talbot, M. D.; A. J. French, M. D.; J. K. Warren, M. D.; E. P. Colby, M. D.

Adjourned at 5 P. M.

PROCEEDINGS

OF THE

FIFTIETH ANNUAL MEETING.

APRIL 9, 1890.

The annual meeting of the Massachusetts Homeopathic Medical Society, was held at Steinert Hall, Boston, Wednesday, April 9, 1890

The meeting was called to order at 10 : 30 A. M., by the President, H. A. Houghton, M. D.

After the reading and approval of the records of the semi-annual meeting, the Treasurer's report, showing a satisfactory balance on hand, was read and approved.

Auditor's report was then read and accepted.

The Necrologist's report contained brief sketches of the following deceased members : —

Gustavus Felix Matthes, M. D , of New Bedford.
H. K. Bennett, M. D., Fitchburg,
L. B. Ballou, M. D., Concord,
Henry A. Brown, M. D., Reading,
W. B. Chamberlain, M. D., Worcester,
H. P. Hemenway, M. D., Somerville,

and was accepted.

The following candidates were then elected to membership : —

Hermann A. Fick, M. D., Boston.
Mortimer H. Clarke, M. D., Auburndale.
Lucy Appleton, M. D., Boston.
Annie I. Lyon, M. D., Haverhill.

The President then announced the polls open for the election of officers.

REPORT OF THE COMMITTEE ON CLINICAL MEDICINE.

N. W. RAND, M. D., *Chairman.*

Subject, Tuberculosis.

I. History. J. K. Culver, M. D.
II. Prevention of. H. A. Gibbs, M. D.
III. Climatology. E. L. Mellus, M. D.
IV. Treatment. Stella M. Perkins, M. D.
V. Consumption in New England. N. W. Rand, M. D.
VI. Psora or Tuberculosis? A. F. Moore, M. D.
VII. Coincidence or Contagion? George F. Forbes, M. D.
VIII. Clinical Case. O. W. Roberts, M. D.

DISCUSSION.

Dr. H. C. Clapp said that he regarded this report as one of the most valuable and interesting the Society had received for some time. Is especially glad that the idea of the contagious character of tuberculosis is gaining ground. The decrease in mortality as shown by the report, is also very gratifying. Thinks the views of some of Dr. Rand's correspondents in regard to the curability of consumption, are rather pessimistic. Believes it possible not only to ameliorate, but to occasionally positively cure the disease. As to prevention, Dr. Clapp would agree with the ideas expressed by Dr. Gibbs, but would have borne still harder upon the importance of maintaining a high standard of health in those predisposed to consumption rather than the effort at destruction of bacilli. Believes that agents not destructive to human life are incapable of destroying bacilli if they have once gained entrance into the system. As to killing them outside that is practically impossible; he therefore urges the necessity of using every possible means to improve the constitution.

The Committee on Change of By-Laws presented a majority report in favor of the proposed amendment and a minority report adverse to it. After considerable discussion it was voted to accept the report and discharge the committee.

A motion was then made to adopt the majority report, but it was lost.

Dr. I. T. Talbot then proposed a modification of the "Australian Ballot System" to govern the nomination and election of officers for the ensuing year, which was duly adopted.

Lunch was served at Hotel Thorndike, of which over one hundred members partook.

At half-past two the meeting was again called to order, and the Society listened to a most interesting address by the President, H. A. Houghton, M. D.

REPORT OF COMMITTEE ON OBSTETRICS.

GEORGE R. SOUTHWICK, M. D., *Chairman.*

I. A Clinical Case. Sarah E. Sherman, M. D.
II. Antisepsis in the Lying-in Chamber. N. R. Perkins, M. D.
III. Discussion. Opened by H. E. Spalding, M. D.
IV. A Clinical Case. George H. Earle, M. D.
V. Presentation of Device to aid delivery by Obstetric Forceps. J. H. Osgood, M. D.
VI. Care of Prematurely Born, or Weak Infants, with presentation of Incubator for maintaining the temperature of the body. G. R. Southwick, M. D.

Dr. H. E. Spalding opened the discussion on Antisepsis in the Lying-in Chamber. He spoke of the vast number of lives which have undoubtedly been lost, both in hospitals and in private practice by septicæmia. The improved results of habitual practice are undoubtedly due to antiseptic precautions taken. In the German Hospitals a two-and-one-half per cent. solution of carbolic acid was used for cleansing the hands. Before confinement the patient is cleansed carefully, and during labor a pad saturated with some antiseptic solution is placed over the vulva. As a result of these precautions they are able to report less than one per cent. of deaths.

The sources of contagion are various. The contagiousness of puerperal fever is to-day unquestioned; whether it can be developed from other infectious diseases as scarlatina, diphtheria or erysipelas is still an open question; is of the opinion that it can not. The same is true of the disease being transmitted by the physician; believes that precautions can be taken so that the physician need not carry the disease. In regard to the value of douches, does not use them so frequently as formerly, and now principally for cleanliness. Unless I have had to introduce my hand within the uterus, or there has been retained fragments of fœtus, placenta, or membranes, I do not use the intra-uterine douche at all.

Dr. Southwick. — In St. Petersburg a solution of chloride of lime is used two or three hours after delivery and repeated several times in the first forty-eight hours. In Halle, a solution of sulphite of soda, permanent irrigation up to the fundus for a week. Fritch to-day is very much opposed to the vaginal douche before delivery and, indeed, many prominent obstetricians abroad

oppose all forms of internal antisepis. In the New York maternity the mortality is now only 1.06 per cent. A vaginal douche is given before delivery, and intra-uterine after delivery if the uterus has been invaded. Curetting the uterus is in vogue if any symptoms of septicæmia. A large blunt curette is used. Prof. Lusk calls intra-uterine douches harmful, and this is the sentiment of the American Gynæcological Society. Another point insisted upon by Lusk is that the use of antiseptics does not warrant a man in attending labor cases if attending infectious diseases.

Dr. Hastings has never used antiseptic precautions and has met with success equal to that of most practitioners. Has been intimately acquainted for sixteen years with a private lying-in hospital, and in all that time, with a record of five hundred or six hundred cases, there has never been a case of septicæmia. Perfect cleanliness has been observed. Honestly believes the whole secret of the results from antiseptic precautions lies in the one word, cleanliness.

Dr. Tower, of Watertown, while treating a case of malignant erysipelas attended five cases of confinement, and with the precaution of washing the hands had not a case of septicæmia.

Dr. Barnard endorses Dr. Hasting's opinion and goes still further. Has attended cases where the surroundings were positively filthy and yet had no trouble. Has attended over five hundred cases and lost but one, and that from traumatism. Believes in cleanliness and antiseptic measures, but does not regard the latter as necessary for safety.

Dr. West does not believe in riding a hobby. In a large hospital much needs to be done, which can be safely left undone in private practice. The person born at his first confinement case will be fifty-four years old next September. Has had the average number of cases since that time amongst all classes of people and cases, and has never had a death from puerperal fever, and has never used an antiseptic during the whole time.

The election of the following list of officers was announced:

President, James Hedenberg, M. D., Medford.

Vice-Presidents, A. J. French, M. D., Lawrence; J. K. Warren, M. D., Worcester.

Corresponding Secretary, J. Wilkinson Clapp, M. D. Brookline.

Recording Secretary, F. C. Richardson, M. D., Boston.

Treasurer, H. C. Clapp, M. D., Boston.

Librarian, Horace Packard, M. D., Boston.

Censors, Walter Wesselhoeft, M. D., Cambridge; E. P. Colby, M. D., Wakefield; D. B. Whittier, M. D., Fitchburg; J. P. Sutherland, M. D., Boston; H. A. Houghton, M. D., Charlestown.

REPORT OF COMMITTEE ON NERVOUS AND MENTAL DISEASES.

E. P. COLBY, M. D., *Chairman.*

I. Clinical Significance of Oxaluria. Wm. L. Jackson, M. D.
II. Myxœdema. George S. Adams, M. D.
III. A Pathological Contribution. George O. Welch, M. D.
IV. Paper. N. Emmons Paine, M. D.
V. Report of Case. E. P. Colby, M. D.

Owing to the lateness of the hour, these papers were not discussed, and the following paper was read by title.

Scientific Basis of Homeopathy. John J. Shaw, M. D.

The meeting adjourned at 5.30 P. M.

PROCEEDINGS

OF THE

FIFTIETH SEMI-ANNUAL MEETING.

OCTOBER 8, 1890.

The semi-annual meeting of the Massachusetts Homeopathic Medical Society was held at Steinert Hall, Boston, Wednesday, Oct, 8th, 1890.

The meeting was called to order by the President, James Hedenberg, M. D., at 10.30 A. M.

After the reading and approval of the records of the Annual Meeting, and the reading of the records of the meetings of the executive committee, the following candidates were elected to membership: —

Henry Rich Higgins, M. D., Allston.
Annie M. Gannon, M. D., Boston.
James Krauss, M. D., Malden.
Nehemiah B. Ford, M. D., Boston.
Samuel Lewis Eaton, M. D., Newton Highlands.
Geo. S. Adams, M. D., Westborough.
Wilhelmus B. Robinson, M. D., Shelburne Falls.
Anna M. Chipman, M. D., Boston.
D. A. Babcock, M D., Fall River.
Homer Brooks, M. D., Haverhill.
S. R. F. Lantzius-Beninga, M. D., Boston.
G. E. White, M. D., Sandwich.

REPORT OF THE COMMITTEE ON SURGERY.

HORACE PACKARD, M. D., *Chairman.*

The following list of papers was presented, and gave rise to interesting discussion:

I. **Treatment of Fracture of the Patella. Winfield S. Smith, M. D.**
II. **Fracture of the Patella. John J. Shaw, M. D.**
III. **Appendicitis, with Report of Cases. Horace Packard, M. D.**

DISCUSSION.

Dr. Scales related a case of transverse fracture of the patella, in which he used a board extending from the ankle to a point just below the hip, fastening this to the limb by strips of adhesive plaster all the way up and down, to overcome muscular contraction; no bandaging was done, and the result was excellent. The patient was kept in bed sixty days.

Dr. Lougee, speaking of appendicitis, thought there were two sides to this question, as to all others. Believes that a great many cases can be pulled through without operation. Has had many cases, no deaths, and no operations. There is one excellent remedy for obstruction in cæcum, etc., and that is thuja. Depends upon thuja, cold water and opium. Believes that ninety-nine out of a hundred cases treated this way will recover.

Dr. Warren mentioned a case of appendicitis which presented no pain until the case was well advanced, and inquired if Dr. Packard had ever met with such cases. In reply to a question by Dr. Lougee, said that in this case there was no perforation.

Dr. H. L. Chase has had several cases of appendicitis, and they have died. In one case the autopsy revealed a peanut in the appendix. In this case there was no operation, and probably an operation, with the light of present knowledge, would have saved the patient.

Dr. Bell has known two cases of appendicitis recover. One under bell., the other under magnes. phos.

Dr. Jos. Chase mentioned a case in which the severe pain was restricted to the epigastrium, and aggravated by pressure in right iliac region; it proved to be a case of appendicitis, and recovered under thuja.

Dr. Horace Packard closed the discussion. He said Dr. Lougee's acknowledgment of having had many cases showed the wide-spread prevalence of appendicitis. Fortunately his cases recovered without operation, but he should certainly urge operation in all cases of undoubted appendicitis. In regard to pain, it is an established fact that when deep pressure is made, a focus of tenderness will be found one and one-half to two inches above the anterior superior spinous process, on a line to the umbilicus.

The appendix seems more intolerant of foreign bodies than other parts of the intestinal canal.

Does not believe that a peritonitis is ever set up without perforation.

REPORT OF THE COMMITTEE ON OPHTHALMOLOGY AND OTOLOGY.

L. HOUGHTON KIMBALL, M D., *Chairman.*

I. Reflex Disturbances arising from the Ocular Muscles, with Case. John H. Payne, M. D. Comments, F. C. Richardson, M. D.

II. A Case of Basilar Fracture of the Skull, extending through the tympanum, with recovery and restored hearing. Howard P. Bellows, M. D.

III. A Case of Orbital Cellulitis and Abscess. L. Houghton Kimball, M.D.

DISCUSSION.

Dr. F. C. Richardson mentioned several cases of functional neuroses, including migraine, and in one case profound mental depression, bordering on melancholia, which had been greatly relieved by attention to existing ocular defects.

Dr. J. H. Payne spoke of a case of chronic diarrhœa, apparently due to eye-strain, which was cured by operation.

There being no further discussion, the Society went into business session.

On motion of Dr. I. T. Talbot, it was voted, after some discussion, that

"The executive committee be instructed to arrange for the fitting celebration of the semi-centennial anniversary of the formation of a Homeopathic Medical Society in the State of Massachusetts, such celebration to take place Tuesday, Dec. 23rd, 1890.

On motion of Dr. A. J. French, it was voted that "Dr. I. T. Talbot be invited to act with the executive committee in preparing for such celebration."

At 1 P. M. the members repaired to Hotel Thorndike, where one hundred and sixteen spent a very pleasant hour at table, after which Dr. Horace Packard delivered an extremely able and interesting oration, entitled "Homeopathy; its Present Relation to the Old School," for which he received the thanks of the Society.

The meeting was again called to order at Steinert Hall, at 2.30 P. M.

REPORT OF THE COMMITTEE ON MATERIA MEDICA.

C. WESSELHOEFT, M. D., *Chairman.*

Drug Analyses. C. Wesselhoeft, M. D., and J. P. Sutherland, M. D.

Dr. Wesselhoeft presented analyses of three drugs with explanatory remarks, and these, with the exhibition of sample "charts" by Dr. Sutherland, rendered the report extremely interesting, as well as instructive.

REPORT OF THE COMMITTEE ON GYNÆCOLOGY.

N. W. EMERSON, M. D., *Chairman.*

I. Laceration of the Cervix Uteri. Martha E. Mann, M. D.
II. A Case of Double Uterus, with Stenosis of Right Segment, and Retention of Menstrual Fluid. Horace Packard, M. D.

After brief discussion of Dr. Packard's case, the meeting adjourned at 5 P. M.

PROCEEDINGS

OF THE

FIFTY-FIRST ANNUAL MEETING.

APRIL 8, 1891.

The annual meeting of the Massachusetts Homeopathic Medical Society was held at Steinert Hall, Boston, Wednesday, April 8, 1891.

The meeting was called to order at 10 : 25 by the President, James Hedenberg, M. D.

The reports of the treasurer, auditor, and necrologist were read and accepted.

The following candidates were then elected to membership : —

Howard C. Jewett, M. D., Haverhill.
George F. Lewis, M. D., Bristol.
Charles W. Morse, M. D., Salem.
J. Summerfield Sanborn, M. D., Nantucket.
Lucy Chaloner Hill, M. D., Fall River.
Anna B. Taylor, M. D., Somerville.
Samuel H. Spalding, M. D., Hingham.
Joseph Emmons Briggs, M. D., Boston.
George H. Talbot, M. D., Newtonville.
Eloise Augusta Sears, M. D., Waltham.
S. Saltmarsh, M. D., Lexington.
Wesley B. Perkins, M. D., Malden.
A. E. Perkins, M. D., So. Ashburnham.
Sarah A. Jenness, M. D., Boston.
W. S. Hincks, M. D., Hyde Park.
T. R. Grow, M. D., Rockport.
E. B. Coleman, M. D., Nantucket.
Daniel E. Brown, M. D., Brockton.
Benjamin P. Barstow, M. D., Kingston.

George P. Sword, M. D., Worcester.
George H. Wilkins, M. D., Palmer.
Francis M. Bennett, M. D., Chicopee.
Maurice Worcester Turner, M. D., Brookline.
W. K. Knowles, M. D., Everett.

The approval of the records of the semi-annual meeting was followed by the reading of the records of the executive committee.

At eleven o'clock the polls were declared open for the election of officers, and Drs. C. H. Thomas and George A. Tower were appointed tellers.

REPORT OF THE COMMITTEE ON CLINICAL MEDICINE.

N. W. RAND, M. D., *Chairman.*

General Subject: Diseases of the Heart.

I. The Heart in Rheumatism. E. H. Packer, M. D.
II. Valvular Diseases. L. F. Potter, M. D.
III. Cardiac Tonics and Stimulants. H. A. Gibbs, M. D.
IV. Clinical Suggestions. H. C. Clapp, M. D.
V. Calcification of Aortic Valves. Case. P. R. Watts, M. D.
VI. Rapid Dilatation from a Blow. Case. F. L. Babcock, M. D.
VII. Functional Disturbance. Case. J. H. Sherman, M. D.
VIII. Examination of the Heart. N. W. Rand, M. D.

DISCUSSION.

Dr. N. R. Morse felt that Dr. Sherman, in his paper, failed to call attention sufficiently to the frequency of "tobacco heart." Is of the opinion that too many of our patients are addicted to, and the victims of, the use of tobacco, and quoted numerous cases of functional heart disturbance entirely relieved by a discontinuance of the use of this drug.

His experience had led him to think many cases erroneously diagnosticated organic heart disease, were amenable to homeopathic medication.

Dr. A. J. French regretted that more had not been said in the Report of the Bureau upon the much talked of "heart failure." It seems to be the fad at present to have our patients die of "heart failure," and this probably has been adopted, as has other labor-saving expedients, to relieve the physician of the trouble of searching for some organic cause of the failure. He had at present, however, a patient dying of heart failure without any apparent organic disease.

Dr. William H. Lougee spoke of obscure cases of Bright's disease as a frequently overlooked cause of heart failure, and urged a careful examination of the urine in all cases of failure of circulation.

Dr. F. A. Warner finds arsenicum a very valuable remedy for tobacco heart.

Dr. Edward Holt protested against the use in one of the papers of the terms "cardiac stimulants and tonics," and insisted that we as homeopathists ought to have no use for tonics or stimulants any more than we have for diuretics, cathartics or emetics. We have no need to swerve from the carefully selected homeopathic remedy, except in some rare cases for the removal of the cause of disease.

This position was vigorously discussed by Drs. Rand, Klein and others, they contending that many times it became necessary for the welfare of the patients that we administer medicine in physiological doses, as for the elimination of uræmic poison, the evacuation of an obstructed bowel, or to empty a stomach of poisonous contents. Drugs used for these purposes should have some special designation, and the terms objected to by Dr. Holt were convenient and useful as descriptive of the action of physiological doses of certain agents.

After some further discussion of the papers presented, the bureau was closed.

Dr. I. T. Talbot wished to say a few words in regard to homeopathy in Massachusetts. We may congratulate ourselves upon the general success of our movements at the present time. Improvements now being made on our hospital will enable us to care for one hundred and fifty-five patients in the near future. The new dispensary building is up to its second story, and although we have not the funds to complete it at present, we shall have greatly increased facilities for dispensary work. A fair is to be held to aid in the erection of this building and it must be a success. He referred to the unrestricted use of arsenic and to the efforts made in the past to secure legislation upon the matter. It remained for the Massachusetts Homeopathic Medical Society to take this fight up and bring it before the Legislature and the public. The matter is now before the committee and we have brought a mass of testimony, embracing hundreds of cases of poisoning, in support of our plea for protection of the people against this evil. But wealthy, unscrupulous corporations are our opponents, and if we are to be successful it can only be by the influence each one of us can bring to bear upon our individual legislators.

Dr. Talbot then read a letter from the Secretary of the Melbourne Homeopathic Hospital introducing Dr. ——— of Melbourne, Australia, and the gentleman received a cordial greeting from the members present. The doctor sketched briefly the struggles and victories of homeopathy in Australia, its growth from a small beginning to its present representation by a splendid hospital standing on three acres of ground, and accommodating one hundred and fifty patients.

The meeting then adjourned, and the members repaired to

Hotel Thorndike, where about one hundred and twenty-five sat down to a satisfactory and well-served lunch.

The meeting was again called to order at Steinert Hall, at half-past two o'clock, and the President, Dr. James Hedenberg, delivered an interesting address, retrospective in character, for which he received the thanks of the Society.

REPORT OF THE COMMITTEE ON DISEASES OF CHILDREN.

The only paper presented was one entitled "The Children and the Doctor," by J. J. Shaw, M. D., Chairman of the Committee.

REPORT OF THE COMMITTEE ON OBSTETRICS.

H. E. SPALDING, M. D., *Chairman.*

I. A few Hints from recent Obstetrical Literature. H. E. Spalding, M. D.
II. Paper. Walter Wesselhoeft, M. D.
III. The Vaginal Syringe in Obstetric Practice. H. M. Hunter, M. D.
IV. A Case: A large Uterine Tumor developed during Pregnancy. Hysterectomy. Samuel H. Spalding, M. D., and N. W. Emerson, M. D.

The papers of this Bureau were of great interest, but received no discussion.

The tellers announced the election of the following officers for the ensuing year:

President, A. J. French, M. D., Lawrence.

Vice-Presidents, L. D. Packard, M. D., So. Boston; John P. Sutherland, M. D., Boston.

Corresponding Secretary, J. Wilkinson Clapp, M. D., Brookline.

Recording Secretary, F. C. Richardson, M. D., E. Boston.

Treasurer, H. C. Clapp, M. D., Boston.

Librarian, Horace Packard, M. D., Boston.

Censors, H. P. Bellows, M. D., West Newton; Walter Wesselhoeft, M. D., Cambridge; John L. Coffin, M. D., Medford; D. B. Whittier, M. D., Fitchburg; E P. Colby, M. D., Wakefield.

By vote of the Society, S. M. Cate, M. D., was re-instated as a member of the Society.

REPORT OF COMMITTEE ON NERVOUS AND MENTAL DISEASES.

E. P. COLBY, M. D., *Chairman.*

I. Some Nervous Conditions following Traumatism. E. P. Colby, M.D.
II. Climacteric Neuroses. F. C. Richardson, M. D.

DISCUSSION.

Dr. J. K. Culver spoke of a case of traumatic spine, resulting from a slight wrench, the patient complaining of inability to walk, numbness of the right cheek and right half of the nose, and two fingers on the right hand. In this case the urine would not exceed in quantity a pint in twenty-four hours.

Dr. Colby wished to impress upon his hearers that although these cases are functional in character, they may give rise to most profound disturbance, and in support of this mentioned a case, a patient of Dr. Richardson's, in which there was complete anuria for a period of five days. Of the complete suppression of urine in this case there could be no doubt, as the bladder was repeatedly catheterized, both by Dr. Richardson and himself, and all possible chance of deception was guarded against.

Dr. Richardson wished to say in regard to the case just mentioned, that there was not, at any time, any indication of uræmic absorption, and the first urine voided was normal in quantity, color, reaction, and constituents. The patient complained of severe, diffuse, abdominal pain, the "abdominal shocks" of Charcot, probably. She made a tedious recovery, and is well at the present time, two years after her illness.

Owing to the late hour, further discussion was impossible, and the meeting adjourned about five o'clock.

PROCEEDINGS

OF THE

FIFTY-FIRST SEMI-ANNUAL MEETING.

OCTOBER 14, 1891.

The fifty-first semi-annual meeting of the Massachusetts Homeopathic Medical Society was held at Steinert Hall, Boston, Wednesday, Oct. 14, 1891.

The meeting was called to order at 10:20 by the President, A. J. French, M. D., and the records of the last annual meeting read and approved.

The following candidates were then elected to membership.

George E. May, M. D., Boston.
George S. Woodman, M. D., Newtonville.
Willis H. Sawyer, M. D., Roxbury.
M. E. Mosher, M. D., Boston.
Clara D. Whitman-Reed, M. D., Newton.
Henry P. Perkins, M. D., West Newton.
A. H. Powers, M. D., Boston.
E. E. Hale, M. D., Attleboro.

A communication from Dr. T. C. Duncan, of Chicago, was read, introducing Dr. W. P. Roberts, of Wisconsin, as a representative of the "American Health Association," and asking that the Massachusetts Homeopathic Medical Society appoint a delegate to investigate the climate of New Mexico.

Referred to the executive committee.

REPORT OF THE COMMITTEE ON SURGERY.

HORACE PACKARD, M. D., *Chairman.*

I. Fracture of the Twelfth Dorsal Vertebra and Complete Section of the Spinal Cord, after which the patient lived four months and eighteen days. Lamson Allen, M. D.

II. The Surgical Treatment of Retro-flexion of the Uterus, with the Report of a Case. W. P. Defriez, M. D.

III. *a.* A Case of Osteomalacia; Amputation at the Lower Third of the Leg; Recovery.

b. A Case of Ventral Hernia; operation abandoned. N. W. Emerson, M. D.

IV. Fracture of the Shaft of the Femur. Charles R. Hunt, M. D.

V. A Case. Death from Ether. James Krauss, M. D.

VI. *a.* A Case of Fracture of the Femur, in a child twelve years old.

b. A Case of Gangrene from the Bite of an Insect. N. R. Perkins, M. D.

VII. A Case of Stricture of Both Ureters, Double Pyelonephritis, Cystotomy; Death Eight Days after Operation, from Asthenia. L. F. Potter, M. D.

VIII. Compound Fracture of the Tibia and Fibula. A Case. N. W. Rand, M. D.

IX. Tait's Operation Complicated by a Diseased Appendix. W. J. Winn, M. D.

DISCUSSION.

Dr. J. W. Hayward thinks that operative measures in cases of vertebral fracture constitute an important and neglected branch of surgery. Has had many cases of fractured vertebrae and has never known one to recover. Usually the patients have died within three months, but had one live five years. Has met at least twenty cases. Thinks it the duty of surgeons to urge an operation as a possible chance of relief.

Dr. W. J. Winn. — Wyeth reports a case of fracture of the eleventh and twelfth dorsal vertebrae, where the patient was put in a plaster cast and recovered.

Dr. Alonzo Boothby. — Has never made Alexander's operation. But, in its modified form, as described by Dr. Defriez, believes it to be a good thing. Has known of three cases, two of which have been complete successes. Does not think this is a milder operation than ventral fixation. The operation is advised for the very cases suitable for treatment by pessaries. Has cured dozens of such cases by the use of pessaries; yet he does not condemn the operation.

Dr. Defriez: — By the operation much time is saved.

Dr. L. A. Phillips. — Has operated on three of these cases by the modification spoken of in Dr. Defriez's paper, and successfully in

every case. Thinks it should be used when other less serious procedures have failed.

Dr. D. B. Whittier. — Speaking of Dr. Krauss' "Case of death from Ether," suggested reflex action resulting from ligation of the hæmorrhoidal mass, as a possible cause of death, and referred to Dr. Pratt's direction to remove the ligature in case of syncope.

Dr. West. — Thinks that the fatal effect of ether is upon the solar plexus.

In response to an inquiry by Dr. Bell, Dr. Krauss said Squibb's ether was used.

Dr. Bell. — Recently the hospital staff had not found Squibb's ether satisfactory.

Dr. L. D. Packard. — Thinks Dr. West's opinion in regard to the cause of death in the case under discussion is correct. Believes Dr. Krauss exercised all necessary caution in the matter and should be held blameless. Quoted several cases of sudden, unaccountable death from ether, and spoke in favor of the more general use of chloroform.

Dr. Horace Packard. — We must always remember that anæsthetics are dangerous things, and the danger increases with the inexperience of the administrator. People take ether differently, as you all know. In some cases it seems to act as a poison and death comes very suddenly. The danger usually comes from cyanosis, and if the face is completely covered by the ether cone this cannot be observed until the patient has crossed the danger line. Did not consider that Dr. Krauss' patient died of shock. Believes that for general use, and in competent hands ether is the best.

REPORT OF THE COMMITTEE ON OPHTHALMOLOGY, OTOLOGY, RHINOLOGY AND LARYNGOLOGY.

JOHN H. PAYNE, M. D., *Chairman.*

I. The Relation of the Base of the Tongue to many Throat Difficulties. Jos. Chase, Jr., M. D.
II. Stenosis of the Nasal Passages. D. G. Woodvine, M. D.
III. Antisepsis in Nasal Surgery. Howard P. Bellows, M. D.
IV. A Case of Madarosis, with Cure by Internal Medication. John H. Payne, M. D.
V. Otorrhœa in Children. A. A. Klein, M. D.

Owing to the fact of the lunch hour having arrived, these papers were not discussed.

At 1.30 P. M. a very satisfactory lunch was served at Hotel Thorndike to 127 members.

AFTERNOON SESSION.

When the meeting was again called to order at Steinert Hall, the President, Dr. A. J. French, made a brief address.

The orator, Dr. Sarah E. Sherman, then delivered the oration, "The Regular Medical School."

REPORT OF THE COMMITTEE ON MATERA MEDICA.

C. WESSELHOEFT, M. D., *Chairman.*

Dr. C. Wesselhoeft spoke at length in regard to methods of forming works on Materia Medica, and has promised his remarks for publication.

He was followed by Dr. John P. Sutherland, who read a paper entitled "Notes on Pharmacy."

Dr. J. Wilkinson Clapp called attention to the fact that at present the homeopathic pharmacists in different parts of the country, followed very different methods in the preparation of their remedies, there being no definite standard of strength. The confusion and even danger resulting from this independent, go-as-you-please style of pharmacy, and the desirability of establishing a uniform standard of strength and regular methods of preparation, must be apparent to all. With this object in view, the American Institute appointed a committee on pharmacopœia, and this committee had so far completed its work that we may look for a perfected National Pharmacopœia, at no distant day.

REPORT OF THE COMMITTEE ON GYNÆCOLOGY.

GEORGE R. SOUTHWICK, M. D., *Chairman.*

I. Treatment of Erosions of the Cervix Uteri. M. E. Mann, M. D.

II. Electricity in Gynæcology, with especial Reference to Apostoli's Methods. Walter H. White, M. D.

III. Significant Uterine Discharges at the Climacteric in Reference to Diagnosis and Treatment. L. F. Potter, M. D.

IV. Some New Applications. Cases Illustrating Malignant Degeneration of Benign Tumors, and the Effect of Pregnancy on Chronic Posterior Displacement of the Uterus. George R. Southwick, M. D.

DISCUSSION.

Dr. H. P. Perkins questioned the value of the Apostoli treatment, and thought the originator had himself expressed dissatisfaction with his results.

Dr. W. H. White. — Has seen considerable of Apostoli and his work during the past summer, and has heard nothing expressive of dissatisfaction. On the contrary, the results have been almost uniformly good, the patients all being relieved in varying degrees.

Dr. W. H. Jackson. — There can be no doubt of the value of the method under discussion. Apostoli does not claim to cause disappearance of the tumor in every case, but patients are almost invariably relieved of the hemorrhage, pain and distressing symptoms so common in these cases.

Dr. H. E. Spalding. — Spoke of the effect of pregnancy in correcting retro-flexions, but does not expect relief unless the patient remains in the recumbent position.

The meeting adjourned at 5 o'clock, after a very satisfactory session. The attendance was large throughout the day, and the interest sustained to the end.

PROCEEDINGS

OF THE

FIFTY-SECOND ANNUAL MEETING

APRIL 13, 1892.

The annual meeting of the Massachusetts Homeopathic Medical Society was held at Steinert Hall, Boston, Wednesday, April 13, 1892.

The meeting was called to order at 10 : 30 A. M. by the President, A. J. French, M. D., and the records of the semi-annual meeting and of the meetings of the Executive Committee were read and approved.

The following candidates were then elected to membership :

Julia A. B. Russell, M. D., Malden.
Kate G. Mudge, M. D., Salem.
Frederick A. Davis, M. D., Boston.
Julia F. Woodman, M. D., Boston.
John H. Bennett, M. D., Boston.
Cyrus W. Scott, M. D., Andover.
Georgianna W. Harris, M. D., Boston.
Winslow B. French, M. D., Brighton.
S. Willard Coy, M. D., Boston.
William T. Hopkins, M. D., Lynn.

The President then appointed the following Tellers : Drs. E. A. Murdock, F. D. Stackpole, James Hedenburg, and at 11 A. M. declared the polls open for the election of officers for the ensuing year.

REPORT OF COMMITTEE ON CLINICAL MEDICINE.

FRED'K B. PERCY, M. D., *Chairman.*

I. A Few Cases of Asthma. Fred'k B. Percy, M. D.
II. The Epidemic of Influenza in Worcester County. Chas. L. Nichols, M. D.

III. A Clinical Case. N. R. Perkins, M. D.
IV. Traumatism as a factor in disease, with two clinical cases.
Fred'k A. Warner, M. D.
V. Was it a case of La Grippe? Samuel L. Eaton, M. D.
VI. Abdominal Elephantiasis. D. E. Brown, M. D.
VII. A case of spinal abscess. J. K. Culver, M. D.

These papers were all of unusual interest and elicited the following:

DISCUSSION.

Dr. E. P. Scales wished to endorse the use of sambucus in asthma. In his hands it had proved a most satisfactory remedy in many cases.

Dr. H. E. Spalding had noticed toward the subsidence of the recent epidemic of grippe that many cases presented a subnormal temperature. This was so marked as to be regarded by himself and others as a diagnostic symptom, and was often a forerunner by twenty-four hours of the fever.

Dr. Joseph Chase spoke of several cases of asthma, reflex from nasal obstruction removal of which relieved the asthmatic trouble.

Dr. Edward B. Holt spoke of the remarkable success of homeopathic treatment in the late epidemic of influenza, and thought that its demonstrated superiority over other methods of treatment should be brought more forcibly to the attention of the profession at large.

Dr. N. R. Morse suggested that Dr. Eaton's doubtful case might have been one of malignant scarlatina instead of "la grippe." Thinks that homeopathists lose comparatively few cases of influenza or pneumonia. Is heartily in favor of the cold pack in the treatment of these diseases.

Dr. Frank A. Gardner wished to add his testimony in favor of the cold pack in "la grippe." Thinks one reason for the poor results of old-school treatment of this disease is the use of antipyretics which strongly depress the already weak heart.

Dr. Frederick A. Warner in reply to a question, said that in the treatment of the cases of albuminuria mentioned in his paper, he used the dilute nitric acid strong enough to slightly acidulate the water.

Dr. N. W. Rand reported a case of influenza, during the entire progress of which the patient was either comatose or wildly delirious.

Dr. A. A. Klein spoke of the frequent occurrence of purulent otitis following "la grippe."

Dr. F. W. Elliott has lost but two cases of pneumonia following "la grippe," in each of which the patient was addicted to the alcohol habit.

Dr. W. H. Lougee has always believed that "la grippe" was a neurosis and not contagious. One object of his treatment has always been to allay the condition of irritability which almost always exists, and to effect this he does not hesitate to give opiates. He also relies on phenacetin to reduce high temperature. He regards the bronchial

type of the disease as the most troublesome ; the first, or spasmodic stage of this type should be relieved by sambucus, but this remedy has disappointed him in this respect. The disease rapidly runs into the suppurative stage in which he has found hepar, mercurius, and aconite most useful. In regard to Dr. Warner's use of nitric acid in puerperal albuminuria it was his opinion that the cases would have recovered spontaneously, and doubted the efficacy of nitric acid in true Bright's disease.

Dr. Gardner spoke of the very gratifying results he had obtained from the use of the cold pack in the treatment of albuminuria.

Dr. A. J. French wished to call attention particularly to the profound effect of " la grippe " upon the nerve centers as the probable cause of many of the reported sudden and otherwise unaccountable deaths. Thinks that the disease is due to an atmospheric influence. Believes in the microbe theory.

Dr. O. S. Sanders regards discussion as to the etiology of " la grippe " as rather profitless. Thinks there is a great deal of speculation about the cause of disease, and that when we draw away from the totality of symptoms we get upon an open sea of doubt and uncertainty. Thinks that with the law of similars and good common sense the patient stands the best chance of recovery from " la grippe " or anything else.

This closed the discussion, and at 1 P. M. the meeting adjourned to Hotel Thorndike, where a very satisfactory lunch was served to 106 members.

The meeting was again called to order at Steinert Hall, at 2 : 30 P. M., by L. D. Packard, M. D., the President being unavoidably absent.

Dr. I. T. Talbot offered the following resolution :

Resolved, That the thanks of the Massachusetts Homeopathic Medical Society are hereby tendered to the State of Massachusetts for the aid received through the State officials whereby the Massachusetts Homeopathic Hospital has been greatly enlarged and its usefulness increased ; to the City of Boston and the generosity of many individuals for the erection of a fine Dispensary building, and to the Trustees of Boston University for the spacious addition to the School of Medicine ; and we pledge our influence as a society to assist these institutions to fully meet the responsibilities which rest upon them. Carried unanimously.

The following resolution was also adopted :

Resolved, That a committee of three on the part of the Massachusetts Homeopathic Medical Society, together with one from each of the other Homeopathic Medical Societies and institutions of the State,

be appointed by the Executive Committee of this society to have charge of and represent the Homeopathic interests of this State at the Columbian Exposition or Fair, to be held at Chicago in 1893.

Dr. J. Wilkinson Clapp, in behalf of the Faculty of Boston University School of Medicine, invited the Society to hold its next semi-annual meeting at the new college building. By vote of the Society this invitation was accepted.

REPORT OF COMMITTEE ON OBSTETRICS.

WALTER WESSELHOEFT, M. D., *Chairman.*

I. A Few Cases of Puerperal Albuminuria without Convulsions. John J. Shaw, M. D.

DISCUSSION.

Dr. E. P. Colby has had the rare privilege of having under continuous observation for a period of eighteen years a patient, with albuminuria. At his first attendance upon the woman, eighteen years ago, her labor was normal, but at a previous confinement she had had albuminuria and convulsions. He has at intervals examined her urine since that time, and always found albumin until two years ago, when, at the climacteric, the albumin gradually disappeared, the headaches grew less frequent, and the woman was now apparently well.

Dr. J. Herbert Moore wished to remind the members that a congestion of the Malpighian tufts may cause albuminuria without the co-existence of true tubular nephritis, and spoke of the frequent existence of nephritis without albuminuria.

Dr. J. P. Sutherland said that the question of the relation of albuminuria to convulsions is not so important as that of nephritis to convulsions. Scarcely a pregnant woman will go to term without the occurrence of albuminuria, yet in the majority of these cases the urine will show no diminution of the excretion of urea and no casts. Has seen actual nephritis existing and yet no sign of convulsions.

REPORT OF COMMITTEE ON DISEASES OF CHILDREN.

J. H. SHERMAN, M. D., *Chairman.*

Subject: "Diphtheria, including Intubation."

I. Treatment of Diphtheria, with Report of a Case. J. H. Sherman, M. D. Discussion opened by L. D. Packard, M. D.

II. Intubation. Eloise A. Sears, M. D. Discussion opened by Horace Packard, M. D.

DISCUSSION.

Dr. L. D. Packard thinks that a certain number of cases of diphtheria are doomed from the very inception, in spite of the most care-

ful and scientific treatment known to-day. Has had very good success in the treatment of this disease with such remedies as phytol., bapt., merc. bin., etc.

Dr. James Hedenberg gave a brief and interesting resume of the history of diphtheria in this country, and spoke in regard to the difference of opinion as to the identity of croup and diphtheria, urging physicians to err in this matter on the side of caution.

The tellers then announced the result of the annual election, as follows:

President, L. D. Packard, M. D., South Boston.

Vice-Presidents, Alonzo Boothby, M. D., Boston; John P. Sutherland, M. D., Boston.

Corresponding Secretary, J. Wilkinson Clapp, M. D., Brookline.

Recording Secretary, Frank C. Richardson, M. D., Boston.

Treasurer, Herbert C. Clapp, M. D., Boston.

Librarian, Horace Packard, M. D., Boston.

Censors, H. P. Bellows, M. D., Boston; N. Emmons Paine, M. D., West Newton; Walter Wesselhoeft, M. D., Cambridge; John L. Coffin, M. D., West Medford; A. J. French, M. D., Lawrence.

It is a pleasure to report the presence at the meeting, of Dr. Robert G. Reed, of Woonsocket, R. I., as a delegate from the Rhode Island Homeopathic Medical Society.

REPORT OF COMMITTEE ON NERVOUS AND MENTAL DISEASES.

FRANK C. RICHARDSON, *Chairman.*

Subject: "Syphilitic Neuroses."

I. General Syphilitic Neuroses. Frank C. Richardson, M. D.

II. Cerebro-Spinal Syphilis, with Remarks on Treatment. E. P. Colby, M. D. Discussion opened by N. Emmons Paine, M. D.

DISCUSSION.

Dr. N. Emmons Paine thinks that the most frequent manifestation of nervous syphilis is general paresis. Considers that at least three-fifths of the cases of general paresis occurring in the male are of syphilitic origin, and probably every case in the female. Where a patient came into the epileptic state after thirty years of age, he, with other observers, had come to regard the case as surely of specific origin. Wished to mention a peculiar form of mental disorder which seemed almost pathognomonic of syphilis. Illustrative of this was the case of a woman who was admitted to the hospital with all the

symptoms of acute mania, but suddenly became quiet, childish, then in a week or two developed total loss of memory, lasting for a long time; she had kali iod, and made a good recovery. A man with the same general excitement at first soon developed the same indescribable forgetfulness, absolute amnesia. but under the iodides made a rapid recovery. Both these cases were known to be of syphilitic origin; they were not cases of general paresis, and the lesion was, in all probability, cortical.

Dr. J. L. Coffin thinks that exclusive of these cases depending upon new growths, syphilitic neuroses are among the most difficult conditions to diagnose. Speaking of syphilitic headache, he thought that severe pain is most likely to occur from syphilitic meningitis, and he has seen these cases cured by gelsemium, cimicifuga, etc., as well as by the iodides and mercurials.

Dr. N. Emmons Paine, speaking of the difficulty of making a differential diagnosis between cerebral tumors, said that he had in one case sent sections of the same tumor, made as closely together as possible, to two eminent pathologists. One called it a glioma, the other a gumma.

Dr. N. W. Rand reported a case diagnosed syphilitic tumor, presenting marked cerebral symptoms which had developed while the patient was under the iodide treatment. After trying various methods of treatment he finally prescribed merc. cor., gr. 1-100 t. d., and from that time the man began to improve, and the cerebral symptoms have now entirely disappeared.

The following committee was appointed by the Chair to take into consideration the recommendation of the executive committee, that the Society adopt the Australian ballot system: Drs. E. P. Colby, I. T. Talbot, Alonzo Boothby, F. B. Percy, F. P. Glazier.

Adjourned at five o'clock.

PROCEEDINGS

OF THE

FIFTY-SECOND SEMI-ANNUAL MEETING.

OCTOBER 11-12, 1892.

The semi-annual meeting of the Massachusetts Homeopathic Medical Society was held at the College building, East Concord St., Boston, Tuesday and Wednesday, Oct. 11 and 12, 1892.

The preliminary meeting was called to order Tuesday evening at half-past seven o'clock, by the President, L. D. Packard, M. D.

The records of the last meeting having been read and approved, the following candidates were elected to membership.

J. Francis Bothfeld, M. D., Westborough.
Ellen L. Keith, M. D., Westborough.
Will Wallace Nutting, M. D., Lowell.
Frank W. Patch, M. D., South Framingham.
George Alson Suffa, M. D., Boston.
Frank C. Walker, M. D., Taunton.
Henrik G. Petersen, M. D., Boston.
James R. Cocke, M. D., Boston.
F. E. Constans, M. D., Brockton.

Dr. Charles L. Nichols, of Worcester, then delivered an eloquent and interesting oration having for its subject, "The Higher Education and Medicine," for which he received the thanks of the Society.

An enjoyable feature of the evening was a social lunch, served at the new Dispensary immediately after adjournment.

Wednesday morning, at nine o'clock, the members were received at the Massachusetts Homeopathic Hospital by the resident phy-

sician, Dr. Thomas M. Strong, and the chairman of the Medical Board, Dr. I. T. Talbot, presented briefly some interesting facts in regard to the hospital and its work.

At 9:30, Dr. Horace Packard demonstrated successfully the use of his apparatus for administering ether by etherated air. Dr. Alonzo Boothby, the attending surgeon for the quarter, then performed a laparotomy, making explanatory remarks as he proceeded.

At ten o'clock the Society assembled in the general lecture room of the College, and the meeting was opened by the following

REPORT OF THE COMMITTEE ON GYNAECOLOGY.

MARTHA E. MANN, M. D., *Chairman.*

I. Notes on a Case of Double Uterus, Ectopic Gestation, Report of Six Cases. Horace Packard, M. D.

II. Diagnosis and Treatment of Cancer of the Uterus. George R. Southwick, M. D.

III. Dispensary Practice Compared with Private Practice. Adaline B. Church, M. D.

IV. An Inquiry. Lucy C. Hill, M. D.

DISCUSSION.

Dr. L. A. Phillips said that Dr. Packard's paper had raised some question in his mind. He doubted that in ectopic gestation impregnation always occurs within the tube. If so, why is the placenta sometimes found attached outside the tube?

He also doubted that haematocele is invariably due to rupture of the sac resulting from ectopic gestation. Thought it might be due to other causes. The statement that septicæmia occurred in extra-uterine pregnancy was contrary to the idea that the external air is necessary to this process.

Dr. J. Heber Smith quoted a case of hæmatocele apparently due to a fall. Of course he could not say positively that there was not ectopic pregnancy previous to the fall.

After some further discussion the Bureau closed, and brief remarks were made by Dr. J. C. Gannett, Secretary of the Maine Homeopathic Medical Society, Dr. W. S. Thompson, of Augusta, Maine, and Dr. Thurber of Providence, R. I.

Other visitors present were Dr. William E. Fellows, President of the Maine Homeopathic Medical Society, Dr. H. C. Bradford, of Lewiston, Me., Dr. H. H. Darling, of Keene, N. H.

REPORT OF THE COMMITTEE ON OPHTHALMOLOGY, OTOLOGY, RHINOLOGY, AND LARYNGOLOGY.

HOWARD P. BELLOWS, M. D., *Chairman.*

I. Deafness as a Sequel of Mumps. Howard P. Bellows, M. D.
II. Location of Pain in Headaches; an Important Factor in Determining the Nature of the Ametropia. John H. Payne, M. D.
III. The Importance of Correcting Slight Degrees of Astigmatism, with Illustrative Cases. L. Houghton Kimball, M. D.
IV. Diseases of the Larynx. D. G. Woodvine, M. D.
V. Reflex Tinnitus and Otalgia. August A. Klein, M. D.

These papers, although of unusual interest, were not discussed.

After a light lunch at noon, the meeting was called to order again at 12 : 30, and Dr. J. M. Barton, Chairman, presented the following

REPORT OF THE COMMITTEE ON MATERIA MEDICA.

I. Each Man His Own Bookmaker in Materia Medica.
Conrad Wesselhoeft, M. D.
II. Colchicum; Its Pathogenesy as Related to Cholera.
J. P. Sutherland, M. D.
III. Poisoning by One of the California Arachnida.
J. Heber Smith, M. D.
IV. Experience with the Schussler Tissue Remedies."
J. M. Barton, M. D.

DISCUSSION.

Dr. A. J. French, discussing Dr. Sutherland's paper, reminded the members that the cause of cholera was a bacillus which no agent yet known could kill. Did not believe that colchicum had the power, and therefore doubted its efficacy in the cure of this disease.

Dr. J. Heber Smith said that he should not use colchicum with much faith in the treatment of cholera. For himself should rely upon cupum acet., 3.

Dr. Sutherland admonished the members not to give up similia similibus in the treatment of cholera because of the "bug."

Dr. Barton spoke of kali phos, as being possibly applicable in cholera because of its being curative of collapse.

About this time it was announced that an "emergency case," had been brought to the hospital, and many of the members availed themselves of Dr. Boothby's invitation to witness an amputation at the shoulder.

REPORT OF THE COMMITTEE ON SURGERY.

ALONZO BOOTHBY, M. D., *Chairman.*

I. Conservative Treatment of Appendicitis. J. W. Hayward, M. D.
II. Three Cases of Appendicitis. Nathaniel W. Emerson, M. D.
III. Twenty-five Hundred Surgical Cases in Roxbury Homeopathic Dispensary. A. H. Powers, M. D.
IV. Treatment of Tumors of the Breast by Electricity. W. L. Jackson, M. D.
V. Some uses of Electrolysis in the Treatment of Cutaneous Blemishes. Fred'k W. Elliot, M. D.
VI. Club-Foot Patients Treated by a New Method. Geo. H. Earl, M. D.
VII. Report of a Case; Fracture of the Unciform Bone by a Fall. Frank A. Gardner, M. D.
VIII. What I have found in Palpating the Abdomen where no Abdominal Growth was suspected. J. R. Cocke, M. D.
IX. Foreign Bodies in the Tissues. I. T. Talbot, M. D.
X. Surgical Diseases of the Antrum of Highmore. J. Emmons Briggs, M. D.

Owing to the large number of interesting papers in this bureau, no time was left for their discussion, and with much regret the President was obliged to close the report immediately after the reading of the last paper. The meeting was then adjourned.

At half-past four the annual Society dinner was served in the new College building. About two hundred and fifty members partook of a very satisfactory banquet, and afterwards spent a very enjoyable evening listening to interesting remarks from the following post-prandial speakers: President L. D. Packard, M.D.; Master of Ceremonies H. E. Spalding, M. D.; Rev. Dr. W. T. Perrin, South Boston; President C. A. Barnard, M. D., of Providence, R. I.; Dr. I. T. Talbot; President W. E. Fellows, of Bangor, Me.; Dr. Frank C. Richardson.

PROCEEDINGS

OF THE

FIFTY-THIRD ANNUAL MEETING.

APRIL 11-12, 1893.

Annual meeting, April 11 and 12, 1893.

The preliminary meeting was held at the College building, Tuesday evening, April 11, the President, L. D. Packard, M. D., in the chair.

After the reading and approval of the records of the semi-annual meeting and the records of the meetings of the Executive Committee, the following papers were presented in the

REPORT OF THE COMMITTEE ON OBSTETRICS.

NATHAN R. MORSE, M. D , *Chairman.*

I. Placenta Prævia, illustrated with stereopticon. George R. Southwick, M. D.
II. The Abdominal Bandage. H. E. Spalding, M. D.
III. Treatment of Abortion. S. Manning Perkins, M. D.
IV. A Case of Puerperal Convulsions. J. H. Sherman, M. D.
V. The Evolution or Mechanics of Labor. Nathan R. Morse, M. D.

DISCUSSION.

Dr. H. L. Chase said that in his first practice he always applied the bandage after confinement, but has not done so for the past twenty years, and has not during this period had nearly so many cases of pendulous abdomen as in earlier times.

Dr. Jos. Chase spoke of the comfort the abdominal bandage afforded the patient during the first day or two, and as it did no harm if properly applied, he thought its use justified.

Dr. N. R. Morse uses the bandage during the first twenty-four hours.

Dr. Sherman thinks that the only excuse for the bandage is the comfort afforded during the first twenty-four hours. Believes pendulous abdomen more apt to occur if bandage is used, than if not.

Dr. Scales has not used the bandage for twenty years and his experience agrees with that of Drs. Chase and Sherman.

Dr. Jos. Chase gave a very interesting description of the posture and customs of the Italian women during parturition.

Dr. Utley reported a case of puerperal convulsions.

Dr. Talbot wished to express his belief in the carefully adjusted bandage. Thinks it is not only a comfort to the woman, but aids materially in preventing pendulous abdomen.

Dr. Boothby heartily endorses the opinion of Drs. Spalding, Talbot and others in favor of the bandage.

Dr. Mosher also spoke in favor of the bandage, and called attention to the fact that the napkin fastened front and back, served to keep the bandage from slipping up.

A vote of the Society being taken on the question of the abdominal bandage, gave a large majority in favor of its use.

Dr. Winthrop T. Talbot exhibited some very interesting pathological specimens, after which the Society adjourned to the small lecture hall, where a collation was served.

SECOND DAY'S SESSION.

The meeting was called to order in Steinert Hall at 10 A. M., by the President, L. D. Packard, M. D.

The report of the Treasurer, Dr. H. C. Clapp, was received, and with that of the Auditor, Dr. F. D. Stackpole, was accepted.

The following candidates were then elected to membership:

Winthrop T. Talbot, M. D., Boston.
John P. Rand, M. D., Worcester.
Fred S. Canedy, M. D., Winchester.
Mary L. Swain, M. D., Boston.
P. J. Wardwell, M. D., Beverly.
Grace E. Cross, M. D., South Boston.
Charles W. Garey, M. D., Quincy.
T. M. Strong, M. D., Boston.
W. Newell Emery, M. D., East Boston.
Fred L. Emerson, M. D., Dorchester.

Robert Chalmers, M. D., Woburn.
J. B. Hines, M. D., Boston.
George J. Searle, M. D., Marlborough.
John F. Worcester, M. D., Clinton.
Emily C. Bruce, M. D., Boston.
Edward D. Fitch, M. D., Worcester.
Helen S. Childs, M. D., Jamaica Plain.
George B. Rice, M. D., Wollaston.
Lottie E. Sampson, M. D., Malden.

The Necrologist, Dr. Charles L. Farnsworth, reported on the death of Drs. Wild and Brooks.

At 10.30 the polls were declared open for the election of officers for the ensuing year.

REPORT OF THE COMMITTEE ON CLINICAL MEDICINE.

A. J. FRENCH, M. D., *Chairman.*

I. The Power and Evolution of Thought. O. S. Sanders, M. D.
II. Supplemental Alimenation as a Factor in the Treatment of Morbid Growths. C. W. Morse, M. D.
III. An Extraordinary Case of Scarlet Fever. W. H. Lougee, M. D.
IV. Action of Zinc in Treatment of Hydrocephalus. G. F. Forbes, M.D.
V. Cholera and its Management. A. J. French, M. D.

DISCUSSION.

Dr. Scales reported his personal experience with cholera while in Washington many years ago, and was happy to say that he owed his recovery to homeopathic medication.

Dr. Leslie, referring to the use of zinc, prefers the oxide to any other preparation, because he has obtained from it the most satisfactory results. He uses it low (2x trit.) and values it very highly.

Dr. H. L. Chase doubts if Dr. Forbes' cases were genuine hydrocephalus. Thinks that zinc is more applicable where there is general tremor instead of for the automatic movements and encephalic cry of true hydrocephalus. Is of the opinion that it is hydrocephaloid, which is cured with zinc.

Dr. L. D. Packard asked Dr. Chase if he would regard as true hydrocephalus, a case where the effusion was so great as to separate the sutures, and said he had seen two such cases recover.

Dr. Scales also reported a similar case which recovered.

Dr. Lamson A. Allen reported a case with tonic convulsions, which was cured with cuprum acet.

Dr. Moore reported a case of actual hydrocephalus following basilar meningitis, the result of la grippe. He prescribed at first bell., and

cold baths, etc., without result in reducing the temperature; by the use of phenacetin, one grain every two hours, he was able to keep the temperature at 102°. Brain symptoms supervened and hydrocephalus developed, effusion being evidenced by dilated pupils, automatic motions, etc. This was two weeks ago and zinc has given such relief as to lead to the hope of complete recovery.

REPORT OF THE COMMITTEE ON DISEASES OF CHILDREN.

J. H. SHERMAN, M. D., *Chairman.*

Subject: — "The Early Care of the Infant."

I. Some advances in the Early Care of the Infant.
James Hedenberg, M. D.

II. The Early Care of the Infant. Anna B. Taylor, M. D.

III. Physical Diagnosis in Children's Diseases. Eloise A. Sears, M. D.

IV. Commonplace Remarks on the General Care of the Infant.
J H. Sherman, M. D.

DISCUSSION.

Dr. Sears thinks the pinning blanket an abomination, and the same of all waist-bands. There has been reformation in woman's dress and there should be in that of children.

Dr. Newton condemns the many and tight clothes with which the infant is usually burdened.

Dr. Mosher wished to go on record as heartily in favor of the daily bath.

Dr. Rand wished to protest against the common practice of winning the good-will of a child by feeding it sugar pills.

Dr. May told of a child eight months old who had been fed on crackers and milk three times a day only, and was perfectly healthy.

Dr. Colby reported the following case: Boy two and a half years old. In May last, when eighteen months old, he fell, producing a complete transverse fracture at the juncture of the middle and upper thirds of the femur. The leg was put in a plaster bandage with extension from one and a quarter pounds weight. The limb was kept in this apparatus for forty-one days from the time of the accident. Union was perfect and power and motions of the leg complete. No shortening. The limb was used perfectly up to about two months ago, when the parents noticed that the child did not walk well with it, nor stand firmly on that side, and there appeared to be some shortening. On inspection by Dr. Colby two or three weeks ago, he found that through rachitic softening of the bones the femur was bending at the site of the united fracture, producing an angular curvature antero-posteriorly and resulting in a practical shortening of the femur. The epiphises of the long bones were much enlarged, typical of rachitis.

Dr. C. wished to make use of some appliance to straighten the femur while the bones were yet soft, and thus prevent the future necessity of a refracture.

Under suspension of the order of exercises the following report of the Committee on Change of By-Laws was presented by the Chairman, Dr. E. P. Colby:

SECTION I. The Secretary shall prepare and send to all members at least sixty days before the annual meeting, a list of officers nominated by the Executive Committee, and also with the notice of the annual meeting an official ballot with the names of candidates, as follows: —

a. The names of the existing officers marked with a *.

b. The name of a candidate for each office, selected by the Executive Committee, marked with a †.

c. The name of a candidate for each office, provided such may have been selected at a caucus of members, and certified to by at least ten members, who were present at said caucus, and who approved of said candidates, marked with a ‡.

d. The names of candidates for each office shall be arranged in alphabetical order.

e. When the same person is nominated for an office by more than one authority, the name need not be repeated, but the *, † or ‡ may be placed before the name to indicate the source of nomination. If any candidate decline the nomination, previously to the printing of the ballot, it shall be so indicated on the ballot.

SECT. 2. The caucus must be held and the names of the candidates thus selected must be placed in the hands of the Secretary, at least one month before the time of the annual meeting.

SECT. 4. Members shall prepare their ballots by making the sign x against the name of the person for whom they desire to vote. If more names are thus marked upon any ballot than there are officers to be elected, the ballot shall not be counted as regards the office for which such excess is marked. This shall not, however, invalidate the ballot for the other offices.

SECT. 4. Ballots must be deposited in the ballot box by members in person, and a check-list shall be kept of all members who vote. Those votes only will be received and counted which are prepared in the official manner herein provided for.

SECT. 5. The notice of the annual meeting shall specify the time during which the ballot box shall be kept open, which shall be at least three hours on the day of the annual meeting.

SECT. 6. The persons receiving the highest number of votes shall be declared elected to the respective offices.

This report was accepted and the recommendations unanimously adopted.

REPORT OF THE COMMITTEE ON NERVOUS AND MENTAL DISEASES.

E. P. COLBY, M. D., *Chairman.*

I. The Care of the Insane in Asylums. W. R. Perkins, M. D.
II. Neurasthenia with Morbid Fears. E. P. Colby M. D.

DISCUSSION.

Dr. N. Emmons Paine being called upon said that he agreed with Dr. Perkins that for the best care of the insane, men were needed who had received the preparation for their specialty afforded by general practice.

Under the head "New Business" an amendment to the By-Laws was offered by Dr. Talbot, providing that the notices shall be sent to members at least two weeks before the meeting. Referred to Executive Committee.

Dr. Lamson Allen then offered an amendment to the By-Laws as follows: "Ballots must be deposited in the ballot box by members in person, or by letter directed to the Secretary and delivered to him before the hour of closing the polls." Referred to Executive Committee.

The meeting was then adjourned.

At 2 P. M. one hundred and fifty members sat down to a most satisfactory dinner at Hotel Thorndike, and after coffee had been served, the President delivered his annual address, which was greatly appreciated by those present.

Dr. A. H. Powers then announced the list of newly-chosen officers as follows:

President, Alonzo Boothby, M. D.

Vice-Presidents, John P. Sutherland, M. D., E. P. Colby, M. D.

Corresponding Secretary, J. Wilkinson Clapp, M. D.

Recording Secretary, Frank C. Richardson, M. D.

Treasurer, Herbert C. Clapp, M. D.

Librarian, Horace Packard, M. D.

Censors, N. Emmons Paine, M. D.; Herbert A. Chase, M. D.; A. J. French, M. D.; L. D. Packard, M. D.; S. A. Sylvester, M. D.

The retiring President then introduced Dr. Boothby, the newly-elected President, whe responded in a few well chosen remarks.

Final adjournment at about 4:30 P. M.

PROCEEDINGS

OF THE

FIFTY-THIRD SEMI-ANNUAL MEETING.

OCTOBER 10–11, 1893.

The semi-annual meeting of the society was held at the College Building, Tuesday and Wednesday, Oct. 10th and 11th, 1893.

On Tuesday, the meeting was called to order by Dr. E. P. Colby, vice-president, the president, Dr. Alonzo Boothy being confined to his house by indisposition.

Owing to a technicality requiring the meeting to be held upon the second Wednesday of the month, reading of the records and balloting for membership were deferred until the following day.

Dr. J. P. Sutherland moved, and the motion was seconded by Dr. L. A. Phillips, that an expression of sympathy be extended by the Society to its president, Dr. Alonzo Boothby, in his present illness, and regret that he should be unable to attend the meeting. Carried unanimously.

The secretary, Dr. Frank C. Richardson, took occasion to publicly thank Dr. Leslie A. Phillips for his kindness in taking charge of the Bureau of Gynæcology at a very late date, and for the very excellent list of papers he has been able to present.

REPORT OF THE COMMITTEE ON GYNÆCOLOGY.

LESLIE A. PHILLIPS, M. D., *Chairman.*

I. The Medical and Mechanical Treatment of Displacement of the Uterus. James R. Cocke, M. D.

II. Progress of Electro-Therapeutics in Gynæcology.
W. H. White, M. D

III. Use of the Faradic Current in Uterine Engorgement.
E. P. Colby, M. D.

IV. Hysterical Convulsions and Laceration of the Cervix.
M. W. Turner, M. D.

V. Perinæal Lesions. F. W. Elliott, M. D.

VI. Relation of the Sympathetic Nervous System to Uterine Disorders.
Leslie A. Phillips, M. D.

DISCUSSION.

Dr. Cocke asked, in regard to statements made in Dr. Phillips' paper, if he could find any record of experiments going to prove that the sympathetic nervous system has entire control of nutritive functions, and Dr. Richardson was asked to reply.

Dr. Richardson thought that we are apt to forget the influence upon the nutritive and vaso-motor functions by the higher centers in the cerebro-spinal system. Thought the function of the sympathetic system not well enough understood at present for positive statements concerning it to be in order. We are too apt to speak of the cerebro-spinal and sympathetic systems as two separate entities, forgetting, apparently, that their functions are as inseparably interdependent as their terminal fibres are inextricably mixed.

REPORT OF THE COMMITTEE ON MATERIA MEDICA.

J. M. BARTON, M. D., *Chairman.*

I. Homeopathic Remedies in Severe Pain. Conrad Wesselhoeft, M.D.
II. The Single Homeopathic Remedy in the Treatment of Malaria. F. W. Patch, M. D.
III. Homeopathic Materia Medica and Diagnosis. J. M. Barton, M. D.

The reading of these papers occupied the time until five o'clock, at which hour a collation was served and the session adjourned.

SECOND DAY'S SESSION.

At 9 A. M. the members assembled in the amphitheatre of the Mass. Homeopathic Hospital, and witnessed a most interesting operation for the relief of epilepsy. Trephining was performed by Dr. Winfield S. Smith, a section of bone measuring two and a half inches in diameter being removed.*

Several other interesting surgical cases were shown, and at half past ten the Society adjourned to the College Building, where the meeting was called to order by the vice-president, E. P. Colby, M. D.

The records of the last annual meeting were read and approved.

* Child made a rapid and uneventful recovery from the operation, seems brighter intellectually, and has had but one convulsion up to date, Oct. 31st.

The following physicians were then unanimously elected to membership:

W. F. Wesselhoeft, M. D., Boston.

Edward R. Utley, M. D., Newton.

Emma J. Peasley, M. D., West Somerville.

Walter Raleigh Amesbury, M. D., Providence, R. I.

REPORT OF THE COMMITTEE ON SURGERY.

W. J. WINN, M. D., *Chairman.*

I. The Present Status of Drainage. N. W. Emerson, M. D.
II. Discussion. Horace Packard, M. D., and others.
III. Ovarian Tumors Complicating Pregnancy; with Report of a Case. Winfield S. Smith, M. D.
IV. Is Erysipelas Curative? A. H. Powers, M. D.
V. The Dangers in Ether Anæsthesia and Their Management. James Krauss, M. D.

DISCUSSION.

Dr. Horace Packard had been much interested in the very timely paper by Dr. Emerson.

The object of drainage is to prevent the complications resulting in septicæmia. The early experience of surgery was that open wounds healed more readily than closed ones. An interesting illustration of the progress of surgery in this respect may be found in the way in which the savage tribes of Africa are learning from missionaries to care for accidental or inflicted wounds. Having passed the stage of open wound treatment, many have learned to sew up the wounds, but not all have yet mastered the principles of drainage, and, consequently, there is frequently found the inflammatory result one would naturally expect.

The inflammation, which we get in badly managed cases, does not come from fluids pent up in cavities, but from the micro-organisms present in incalculable numbers, the evil effects of which vary according to the varying power of resistance present in different patients. In cases of depressed vitality suppuration occurs, and if no drainage has been provided, absorption takes place, the whole system becomes saturated and we have septicæmia. I, therefore, feel safe in providing drainage in the majority of cases. I firmly believe that the depression consequent upon anæsthesia exercises a great influence on the suppurative process.

My guide in the matter of drainage is this: If large areas have been denuded by tearing up adhesions, and there is much oozing of bloody serum, it is my custom to use a drainage tube for at least twenty-four hours.

Dr. Emerson. — Dr. Packard seems to have overlooked the object of my paper. The question is not as to the advisability of drainage but as to the best method of effecting it. My opinion as to the efficiency of strips of gauze as a means of drainage has been assailed and I had hoped to have the matter freely discussed. That drainage is frequently if not generally necessary is, I think, conceded.

REPORT OF COMMITTEE ON OPHTHALMOLOGY, OTOLOGY, RHINOLOGY AND LARYNGOLOGY.

S. A. SYLVESTER, M. D., *Chairman.*

I. A Peculiar Case of Dislocated Lens, in a Highly Myopic Subject. Extraction of the Lens and Cure of the Myopia. J. Howard Payne, M. D.

II. Fitting Glasses. August A. Klein, M. D.

III. Myopia. G. A. Suffa, M. D.

IV. A Disease, a Symptom, and an Accident. A. E. Perkins, M. D.

V. The Human Voice, and its Relation to Disease. D. G. Woodvine, M. D.

VI. A Cure of Persistent Headache Dependent on Chronic Middle Ear Suppuration. H. P. Bellows, M. D.

VII. Chromic Acid in Chronic Enlargement of the Tonsils. S. A. Sylvester, M. D.

VIII. Hay Fever. Geo. B. Rice, M. D.

Because of lack of time these papers were not discussed.

At 1.30 P. M. Dr. J. K. Warren delivered the oration on "Uncertainties in Medicine," which was followed by the banquet, of which one hundred and twenty-five members partook.

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PROCEEDINGS

OF THE

FIFTY-FOURTH ANNUAL MEETING

APRIL 10–11, 1894.

The fifty-fourth annual meeting of the Society was held at the Westborough Insane Hospital, Westborough, Tuesday, April 10, and at Steinert Hall, Boston, Wednesday, April 11, 1894.

FIRST DAY'S SESSION.

About seventy-five members of the Society left Boston Tuesday morning on the 11.10 train, arriving at Hospital Station at 12.20 P. M., where barges were in waiting to convey them to the Hospital.

After partaking of the bountiful lunch provided by the Society, the members repaired to the chapel, where the meeting was called to order by the President, Alonzo Boothby, M. D., and immediately placed in charge of Dr. George S. Adams, chairman of the committee on nervous and mental diseases, who presented the following report:

I. **Myxœdema and Huntington's Chorea. Cases. Ellen L. Keith, M. D.**

II. **The Relationship of Rheumatism to Chorea. Statistics of Sixty Cases. Frank C. Richardson, M. D. Discussion opened by Edwin P. Colby, M. D.**

III. **Statistics of Massachusetts Insane Hospitals for 1893. Mr. A. Blakeslee.**

IV. **Curability of Mental Disease. J. Francis Bothfeld, M. D. Discussion opened by N. Emmons Paine, M. D.**

DISCUSSION.

These papers were freely discussed, especially that by Dr. Richardson, Dr. Colby contending that rheumatism is a most potent causative agent of chorea.

After the closing of the bureau, the members were afforded an opportunity to inspect the Hospital, and at 5.15 the train was taken for Boston. The members much pleased with their courteous reception by Dr. Adams and his colleagues at the Hospital.

At 7 P. M. the officers of the Society received the members, their ladies and invited guests at Hotel Vendome, where at 8 o'clock the annual banquet was served, after which Dr. Alonzo Boothby delivered the President's address, which was received with well merited applause. Congratulatory speeches were made by His Excellency Governor Greenhalge, the Rev. Geo. A. Gordon and Dr. I. T. Talbot, and the company broke up about 11 o'clock, after a most enjoyable evening.

SECOND DAY'S SESSION

The meeting was called to order at 10 o'clock by the President, Alonzo Boothby, M. D., and the records of the semi-annual meeting read and approved. The reports of the Treasurer and Auditor, showing a handsome balance on hand, were received and accepted.

The following candidates were then elected to membership:

H. Ashton Downs, M. D., Somerville.
Clara Rogers Rutter, M. D , Lawrence.
William E. Barnes, M. D., Boston.
George E. Crane, M. D., Foxborough.

Drs. Powers and French were then appointed to serve as tellers, and the polls were declared open for the election of officers.

REPORT OF THE COMMITTEE ON CLINICAL MEDICINE.

N. W. RAND, M. D., *Chairman.*

I. Renal Physiology. J. P. Sutherland, M. D.
II. Practical Points in Urinalysis. J. P. Rand, M. D.
III. Uræmia. Samuel H. Spalding, M. D.
IV. Pathological Specimen. Oxaluria. Lamson Allen, M. D.

V. **Sub-acute Inflammation of the Kidneys. Cases.**
E. P. Scales, M. D.

VI. **Sulphur in a Case of Desquamative Nephritis.**
A. H. Tompkins, M. D.

VII. **Renal Cholic. Experience versus Opinion. A. M. Cushing, M. D.**

VIII. **Renal Cyst. Specimen. W. H. Talbot, M. D.**

IX. **Three Interesting Cases from Practice. James R. Cocke, M. D.**

X. **Urinalysis in One Hundred Cases of Insanity.**
Wm. O. Mann, M D.

DISCUSSION.

Dr. Hopkins asked in regard to the action of the saline solution referred to in Dr. Spalding's paper, and Dr. Spalding stated that the solution was introduced in large quantity upon the theory that in diluting the blood it produced its salutory effect.

Dr. Scales mentioned a case of uræmic poisoning occurring in confinement with fatal result.

Dr. Moore thought Dr. Rand's paper of more than ordinary interest, as showing the importance of testing for urea in chronic cases. He considers this test of more vital importance than that for albumen; thinks, also, that the microscope should be more freely used.

Dr. Scales suggested the advisability of the busy practitioner sending his urinary specimens to a competent analytical chemist.

Dr. Colby wished to protest against presenting in the discussion the word of an allopathic physician as having greater weight or more importance than that of one of our own school.

Dr. J. P. Rand referred to the severe drain upon the system in cases of Bright's Disease; as there was rarely more than an ounce of albumen lost in twenty-four hours why should the system suffer so severely? Dr. Spalding thought this was explained from the fact of non-elimination of waste products.

Dr. N. W. Rand reported a case of renal cyst attached to the kidney.

Dr. A. M. Cushing spoke of the inconsistent use of strychnine by an old-school physician in the recent epidemic of grippe, the drug being given in one case to increase the pulse and in another to reduce it.

Dr. Moore thought that Dr. Cocke's cases could best be explained by the term uræmia, the presence of urea in the blood. In the second case, he thought death was caused by uræmic coma.

Dr. Mann stated that it was now generally conceded that the coma in these cases was not due to the presence of urea in the blood.

REPORT OF NECROLOGIST, L. D. PACKARD, M. D.

Remarks eulogistic of the late Dr. David Thayer were made by Drs. H. L. Chase and B. H. West, while Drs L. D. Packard and

I. T. Talbot spoke in a similar manner of the late Dr. E. U. Jones. This report will be published in full.

At one o'clock the members adjourned to Hotel Thorndike for lunch.

The meeting was again called to order in Steinert Hall at two o'clock, by the president, Alonzo Boothby, M. D.

REPORT OF COMMITTEE ON OBSTETRICS.

G. H. EARL, M. D., *Chairman.*

Subject: "Clinical Obstetrics." Papers presented by J. W. Hayward, M. D., Frank Gardner, M. D., G. R. Southwick, M. D., Geo. H. Earl, M. D.

DISCUSSION.

Dr. Babcock spoke of a case similar to that reported by Dr. Earl, of septicæmia without apparent cause for infection except that arising from the patient's mania for smelling of a foul dish-rag. A peculiarity of the case was the presence in the vagina of a membrane resembling diphtheritic membrane.

Dr. Whittier criticised Dr. Earl's use of ergot in the case reported and also thought he was not warranted in curetting while the uterus was in such an inflamed condition.

Dr. Earl replied that ergot had been given before he saw the case. He felt that curetting was warranted in these cases by the amount of material usually removed.

Dr. H. L. Chase doubts the feasability of washing out and packing the womb and thinks that wiping out with dry cotton is better.

Dr. Boothby thinks that the essential point with curetting is to get away all the septic material. If any is left there is sure to be septic absorption by the denuded surfaces.

Dr. Sherman thinks that high temperature is the essential indication for curetting.

Dr. Boothby feels that there are progressive stages of puerperal infection when interference is dangerous.

Dr. Southwick thinks sepsis is self-generating and all means must in order to be effective be used before the infection has progressed beyond the uterine cavity. Unless the curette can be used in the beginning to remove the entire septic material it had better not be used at all. In the later stages advises to thoroughly cleanse the uterine cavity and pack loosely with gauze.

Dr. Rand believes that not the presence of membrane causes infection but its exposure to air. Believes a simple washing out of detritus which is washable will be as successful as curetting and packing.

In reply to a question Dr. Southwick stated that in his opinion

chill, fever and other recognizable symptoms of septic infection call for irrigation and loose packing. When asked in what percentage of labors he thought such procedure would be required he replied that it would depend upon the care taken to secure asepsis.

Dr. Earl thought that five per cent. of dispensary cases prove infectious.

The Tellers then reported the election of the following officers for the ensuing year:

President, John P. Sutherland, M. D.
Vice-Presidents, E. P. Colby, M. D.; N. W. Rand, M D.
Corresponding Secretary, J. Wilkinson Clapp, M. D.
Recording Secretary, Frank C. Richardson, M. D.
Treasurer, Herbert C. Clapp, M. D.
Librarian, Jane K. Culver, M. D.
Censors, H. P. Bellows, M. D.; N. Emmons Paine, M. D.; Alonzo Boothby, M. D.; Horace Packard, M. D.; F. W. Halsey, M. D.

REPORT OF COMMITTEE ON DISEASES OF CHILDREN.

MARY E. MOSHER, M. D., *Chairman.*

I. Vaccination. Helen S. Childs, M. D.
II. Infantile Eczema. John L. Coffin, M. D.
III. Cervical Lymphangitis in Children. A. H. Powers, M. D.
IV. Hydrocephalus and its Homeopathic Treatment.

Mary E. Mosher, M. D.

DISCUSSION.

Dr. Rand spoke of severe erythema following vaccination in a number of cases under his observation.

Dr. Coffin has seen eight or ten cases of eruption following vaccination, and thinks it not due in any way to the vaccine used. Told of a case of a young man who came to him with a rough, gangrenous slough on his arm, surrounded with the usual reddened areolar, reporting having been vaccinated a month before; a carbolic lotion was advised. The following day the patient presented himself with an inflamed œdematous arm, and the case thereafter followed the usual course of vaccinia. Was it a case of recurrent vaccination without new infection?

Dr. Utley has since December last vaccinated over fourteen hundred people, most of whom belonged to the criminal class, and had noted that syphilis and phthisis do not influence the result.

Dr. Childs thinks the eruption spoken of is most apt to develop in adults with primary vaccination.

Dr. West mentioned the case of his daughter, who, having been vaccinated nineteen times ineffectually, was made very sick by the twentieth vaccination. Also recounted his experience as assistant physician at Rainsford Island during the small-pox epidemic of 1837.

Dr. Richardson felt that the profession and the public at large should feel indebted to the New England Vaccine Co., and especially to its manager, Dr. Cutler, for the lavish expenditure of time, thought and money necessary to bring the production of vaccine virus up to its present scientific standpoint.

Dr. Tompkins reported two cases of acute hydrocephalus cured by homeopathic medication.

Dr. H. L. Chase spoke in praise of zincum for the restlessness of hydrocephalus.

A vote of thanks was extended to the Chairmen of the various bureaus for the excellent reports presented, and thus ended one of the most successful meetings in the history of the Society. The attendance was large throughout; the discussion, though always courteous, was animated and scientific, and it may safely be said that the Fifty-Fourth Annual Meeting has demonstrated the desirability of a two days' session.

PROCEEDINGS

OF THE

FIFTY-FOURTH SEMI-ANNUAL MEETING

OCTOBER 9–10, 1894.

The fifty-fourth semi-annual meeting of the Society was held at Steinert Hall, Boston, Tuesday, Oct. 9th, and at the College Building, East Concord Street, Boston, Wednesday, Oct. 10th, 1894.

The attendance was large and meetings most interesting at both sessions.

FIRST DAY'S SESSION.

The meeting was called to order by the President, John P. Sutherland, M. D., and immediately placed in charge of Dr. Frederick B. Percy, Chairman of Committee on Materia Medica, who presented the following report:

I. Some Remedies in Neurasthenia. Conrad Wesselhoeft, M. D.
II. Notes on Colchicum in Rheumatism. Edward P. Colby, M. D.
III. Verifications. William P. Defriez, M. D.
IV. Bryonia. John J. Shaw, M. D.
V. Belladonna, Bryonia, and Rhus, in Rheumatisms.
J. Heber Smith, M. D.
VI. Ledum Palustre in Rheumatism and Gouty Affections.
Frederick B. Percy, M. D.

DISCUSSION.

Dr. H. E. Spalding regards neurasthenia in the great majority of cases symptomatic of some tangible, diseased condition which is causing reflex nervous manifestation. Therefore the treatment should be directed to the *prima causa* whether this be found in the eye, ear, rectum or elsewhere, and in this way only can we expect to reach the neurasthenia.

Dr. D. B. Whittier thinks that a prime factor in the successful treatment of rheumatism is the elimination of the rheumatic poison by the skin. He therefore endeavors to produce profuse diaphoresis as speedily as possible. For this purpose has made use of a mixture containing acetanilid, caffeine and sod. bicarb. This will produce profuse sweating and relieve the pain. Has never seen any disagreeable cardiac effect from the use of this mixture. Is aware that this treatment is not orthodox but as a palliative, and in conjunction with other remedies it has served good purpose.

Dr. E. P. Scales has treated rheumatism many years and with marked success, and has never been obliged to resort to sweating the patient or to any other adjuvant to the indicated homeopathic remedy.

In reply to a question by Dr. A. H. Tompkins, Dr. Percy said that in the two cases cited from Hughes as cured by ledum palustre, there were in addition to the leading indications, "Aggravation from motion and entire relief when quiet, also aggravation from the warmth of the bed," the additional indication of pain in right hip.

Dr. Walter Wesselhoeft has not a definite idea concerning drug action in rheumatism. There are a few remedies he has come to rely upon as much as any remedy can be relied upon in so hydra-headed a disease as rheumatism. Many conditions are characterized as rheumatic which vary extremely. That sulphur, cimicifuga, colchicum, bryonia, rhus and other remedies can affect rheumatism, nobody can have any doubt. We see unwilling testimony borne to this fact by those, who in the main reject our remedies utterly. A matter of the utmost importance in the treatment of rheumatism is that of diet. While uric acid may play an important part as a causative influence in the production of rheumatism, many cases undoubtedly occur without uric acid poisoning. Has therefore ceased to believe that nitrogenous food is so dangerous as was formerly believed. Thinks that meat in moderate quantities can be allowed in most cases; believes in varied diet and is by no means certain that a milk diet is in all circumstances desirable. Thinks that in the matter of diet we should study our patient's idiosyncracies. Thinks very well of water as compresses, packs, baths and douches; the relief from these is well worth seeking even though it be but fleeting.

REPORT OF THE COMMITTEE ON DERMATOLOGY, SYPHILOLOGY AND GENITO-URINARY DISEASES.

JOHN L. COFFIN, M. D., *Chairman.*

I. Report of Some Cases of Skin Diseases. John L. Coffin, M. D.
II. Differential Diagnosis of Specific and Non-Specific Urethritis. O. B. Sanders, M. D.
III. Report of a Case of Multiple Round Celled Sarcoma. F. B. Batchelder, M. D.
IV. Report of a Case of Syphilis Contracted in an Unusual Way. George B. Rice, M. D.
V. Some Remarks on the Treatment of Gonorrhœa. S. H. Blodgett, M. D.

DISCUSSION.

Dr. Talbot spoke of a case of carcinoma treated by erysipelas toxine unsuccessfully.

Dr. Powers spoke of the not uncommon cases of chronic gonorrhœa and gleet which progress satisfactorily to a certain point, and then remain *in statu quo* in spite of our best efforts. These cases are most difficult to manage, more especially because the necessity for secrecy interferes with the proper enforcement of some of the requisites for successful treatment.

Dr. Southwick. It is the generally accepted opinion that many cases of salpyngitis arise from gonorrhœa, and it is the duty of every physician to treat gonorrhœa in the female promptly and most thoroughly. Most satisfactory results can be obtained from frequent thorough douching with a bi-chloride solution of, say, 1 to 1000, or 1 to 2000.

Dr. C. Wesselhoeft has never hesitated to apply locally the indicated homeopathic remedy. Mercurius corrosivus is indicated in gonorrhœa. Is careful to use a weak solution. One to one thousand is not a weak solution. Has used a solution of one to ten thousand, taking the precaution of telling the patient how to inject into the urethra. Directs him to use a medicine dropper and inject only so far that the solution will not enter the bladder.

Dr. Tompkins has never failed to cure a case of gonorrhœa. Has never made use of injections, and has never found it necessary to depart from the indicated homeopathic remedy. To be sure the cases were sometimes slow in recovering; in a few cases more than six months, but when finally discharged they were well, without stricture or danger of relapse. Thinks our patients should be educated not to expect rapid cures.

Dr. J. H. Sherman wished simply to remark that he had known of some cases of gonorrhœa which had gotten well without treatment, and it only took several months to do it.

Dr. Coffin believes it is most difficult to decide when gonorrhœa is finally cured. Regards syphilis as more amenable to treatment and surer of eradication than gonorrhœa.

At half past six about 125 members assembled at Hotel Thorndike and partook of a bountiful and satisfactory repast. The tables were beautifully decorated with flowers and fairy lamps; the menu cards were tastefully arranged and a general air of hospitality and good-cheer prevailed.

After coffee had been served, President Sutherland called the members to order and introduced the Orator, Henry E. Spalding, M. D., who delivered the annual oration, "Medical Fads, Past and Present. Their Relationship to the so-called Specialties."

It was a most entertaining and instructive effort, well worthy the generous applause it received.

SECOND DAY'S SESSION.

Surgical Clinic at Massachusetts Homeopathic Hospital.

Dr. Horace Packard showed a case of Dupuytren's contraction operated upon a week before, and called attention to the perfect result obtained.

The following cases were then operated upon by Dr. Packard: 1. Chronic appendicitis. 2. Acute appendicitis.

Dr. W. J. Winn exhibited a patient upon whom inguinal colotomy had been successfully performed for the relief of syphilitic stricture.

The meeting was called to order at 10:30 at the College building, by the President, J. P. Sutherland, M. D., and the records of the last annual meeting read and approved.

The following candidates were then elected to membership:

Jennie S. Dunn, M. D., East Boston.
Charles S. Gleason, M. D., Wareham.
J. Herbert Stevens, M. D., Malden.
Noble H. Hill, M. D., Boston.
Frederick P. Batchelder, M. D., Boston.
George E. Hetherington, M. D., Somerville.

REPORT OF THE COMMITTEE ON SURGERY.

A. H. POWERS, M. D., *Chairman.*

I. Diagnosis of Malignant Growths. Nathaniel W. Emerson, M. D.
II. Results of Operation for Malignant Growths. Horace Packard, M. D.
III. Present Status of Electro-Therapeutics in the Treatment of Malignant Growths. W. L. Jackson, M. D.
IV. An Unsuccessful Case of Appendicitis. W. J. Winn, M. D.

DISCUSSION.

Dr. Richardson being called upon said that not having had personal experience in the treatment of malignant growths by electricity, did not feel competent to discuss Dr. Jackson's able paper. Would say, however, that in the case of hidden growths the use of currents sufficient to produce the desired result was attended with great difficulty and danger because of the impossibility of accurately determining the amount of destruction of tissue taking place. This procedure is still under investigation, however, and we are hopeful of being able to place it upon a more scientific basis.

Dr. Elliott thinks that at the present day, with the records of many consecutive successful hysterectomies, and when the operation had been so improved by a Western surgeon that the uterus could be removed without ligating a single vessel, it is inexcusable to hesitate about radical operation if there is any indication of malignant disease.

Dr. Packard explained what is meant by "peri-appendicitis," also the manner in which peritonitis takes place as a result of appendicitis. Many cases of so-called psoas abscess were really appendicular abscess. Also explained how in a few cases nature took care of the inflammatory product and spontaneous recovery resulted.

Dr. Elliott spoke of the recent discussion in regard to the use or non-use of cathartics and olive oil in the treatment of appendicitis, and felt that the use of these agents was worthy of thought in the conservative treatment of the condition under consideration. Operation for appendicitis had been spoken of by Western surgeons as a Boston fad.

Dr. Packard begs the Society not to rush to the conclusion that the operation for appendicitis is a fad or a notion. We have arrived at definite scientific data in regard to the treatment of this condition, and intelligent physicians everywhere, whether West or East, have come to regard operation as a legitimate procedure. Does not think appendicitis so liable to a mistaken diagnosis as most other abdominal pathological conditions.

Dr. Strong during his term of office as Superintendent of the Massachusetts Homeopathic Hospital has seen very many cases of appendicitis and never an unjustifiable operation.

Dr. Powers wished to correct a fallacy entertained by the laity, and, indeed, some physicians, namely, that the cause of appendicitis is necessarily a concretion. Of course we know that this is not so. There are as many or more idiopathic cases. Spoke of the part played by the bacillus of the colon in the production of appendicitis. Mentioned three cases reported by a Philadelphia surgeon, in one of which the appendix was found under the umbilicus, in another underneath the liver, and in the third, in the left inguinal region.

A large experience in post-mortem work has led him to think that the appendix is more rarely found in the place usually described than elsewhere. It should not be special symptoms but the aggregation which should lead to a diagnosis.

Dr. Winn thinks that in the treatment of appendicitis the danger of operation is comparatively nothing to that of letting it alone. Has had four cases recover spontaneously. Speaks highly of the conservative treatment by the cold coil and indicated remedy.

Dr. Whittier. If the appendix is a tramp, and the McBurney point discounted, and the symptoms unreliable, and sweet oil unadmissable, what is the country physician to do who has neither a hospital to retreat to, or noted surgeons to explore the abdomen, except to trust in Providence and "go it blind."

Dr. Packard considers the treatment of malignant growths one of the most important questions of the day. In their treatment we are no nearer success to-day than twenty-five years ago. Has hope that some time we shall be able to prevent by prophylactic means and at least mitigate them where already existing.

Dr. Packard then read statistics of all cases of malignant growths operated upon by him during the last three years, showing the number of relapses so far as known and the period of time intervening in these cases between operation and a return of the trouble. These statistics will be duly published. He spoke at some length of the increased thoroughness with which operation for cancer of the breast is now performed. Formerly, a mere eliptical incision sufficient to excise the nodular mass was thought to be enough; care is at present taken to remove all axillary glands which show a possibility of having been infected.

Dr. Southwick thinks that in the after-treatment of a case by the administration of appropriate remedies much can be done to postpone a return of the trouble. At least one case under his care, in which clinical history and microscopical evidence pointed unmistakably to cancer, is surely getting better under treatment. Thinks highly of arsenicum and carbolic acid in the treatment of these cases, and believes that careful study and attention to medicinal treatment would lead to the development of a therapy of much value.

Dr. Krauss. — If we take into consideration the fact now generally accepted that malignant growths are usually engrafted upon a growth

of benign character, it would seem that much might be done in the way of prophylaxis by early extirpation of growths before malignancy has a foothold.

Dr. Joseph Chase has seen several cases in which impending malignancy seemed to be arrested by medicine.

Dr. Talbot strongly advocates the medicinal (homeopathic) treatment of malignant growths.

REPORT OF THE COMMITTEE ON OPHTHALMOLOGY, OTOLOGY, RHINOLOGY AND LARYNGOLOGY.

G. A. SUFFA, M. D., *Chairman.*

I. A New Method of Plugging the Nostrils. D. G. Woodvine, M. D.
II. Epistaxis. Geo. B. Rice, M. D.
III. Tonsillar Inflammations and Adhesions. S. A. Sylvester, M. D.
IV. Mental Astigmatism. L. Houghton Kimball, M. D.
V. An Unusual Case, with Pathological Specimen. John H. Payne, M.D.
VI. Experience with the Vibrometer in the Treatment of Catarrhal Deafness.

Numbers 1, 3 and 5 were the only papers read; the others were presented by title, their authors being absent.

At 1.30 the Society adjourned for lunch. At 2.30 the meeting was again called to order, and received the

REPORT OF THE COMMITTEE ON GYNÆCOLOGY.

LESLIE A. PHILLIPS, M. D., *Chairman.*

I. Laceration of the Cervix and Endometritis. Alonzo Boothby, M.D.
II. Lacerations of the Vagina and Perinæum. Geo. R. Southwick. M.D.
III. A Few Cases from Practice. Adaline B. Church, M. D.
IV. An Interesting Laparotomy, with Specimen. W. J. Winn, M. D.

DISCUSSION.

Dr. Jos. Chase spoke of the unsatisfactory results from the old methods of repairing the perinæum soon after laceration, also the liability of overlooking lacerations of the vaginal walls; thinks these latter are of much more frequent occurrence than is generally supposed, and that neglect to repair them may lead to much trouble. The idea of saving the perinæum by supporting or other means is in his opinion largely fallacious. In many cases a tear is inevitable. Rapid birth is a prolific cause of laceration. Immediate repair can be accomplished without anæsthesia in most cases. The vaginal wall should be carefully examined in every case and any rupture of continuity, however slight, should be repaired.

Dr. Southwick, in reply to a question, expressed the opinion that in primiparæ laceration is the rule.

Dr. Holt thinks his practice must have been singularly free from

cases of laceration, for he does not recollect of ever finding one. Thinks they may be avoided by continuing the progress of the child in the direction of the pelvic curve after the head has entered the vulva.

Dr. Tower considers that the shoulders cause rupture much more frequently than the head. Many cases of laceration certainly heal without operation.

Dr. Earl wishes to call attention to the fact that in immediate repair, suturing the vaginal mucous membrane causes no pain, and we are thus able to dispense with anæsthesia.

Dr. Newton, while admitting that suturing the mucous membrane may be painless, thinks we should not forget the pain caused by passing sutures through the integument, and wishes to enter a plea for mild anæsthesia. Thinks that the majority of primary operations do not heal, and unless it can be done very carefully it is best to wait.

Dr. Earl finds that packing vagina above the seat of operation lightly with cotton greatly obviates the trouble experienced from blood flowing over the wound, and, therefore, facilitates placing the sutures.

Dr. Southwick wished particularly to call attention to lacerations of the pelvic floor, which, if not attended to, cause much trouble. Counsels thorough work. Merely stitching the integument does no good and is a waste of time.

Dr. Boothby wishes to most positively condemn any statement, such as he understood had been made at this meeting, that removal of the uterus is a perfectly safe procedure. Such assertion is ill-considered and liable to cause mischief. To be sure, great progress has been made in the technique of performing hysterectomy, but those who have met with the largest measure of success and done the most to bring the operation to its present approach to perfection, have accomplished this because of their realization of the dangers involved and the extreme caution they have used in avoiding these dangers. Furthermore, no man on earth ever removed seventy-five or a hundred uteri, consecutively, or any other way, without tying a vessel. The statement is preposterous, and only to be credited by those unacquainted with the anatomy of the parts. Vessels must be cut and a cut vessel will bleed, whoever cuts it, whether the surgeon hails from conservative Boston or braggart Chicago.

Dr. Lamson Allen believes that occasionally lacerations so slight as to have been at first overlooked, have caused reflex symptoms only relieved by operation.

Dr. Adaline B. Church thinks physicians are liable to go to extremes in promising relief of reflex symptoms by operation. Oftentimes, the mere shock of telling a patient that an operation is necessary has cured neurasthenia. We have severe cases of bi-lateral laceration with extensive cicatricial plug causing grave reflex symp-

toms which can only be benefited by operation, but the accompanying endometritis may be almost as important a cause of trouble and should not be neglected.

Dr. Southwick thinks the dysmenorrhœa so frequently following operations on the cervix is usually due to the fact of the operation having been improperly performed by the inexperienced. It is not so simple an operation as many seem to suppose.

Dr. Elliott does not regard curetting as a simple operation either. His first curettement was followed immediately by salpyngitis and a little later by ovariotomy, and this when every antiseptic precaution had been observed. Thinks dilatation by means of graded sounds possesses many advantages over that by the dilators in common use. Reported a case of dysmenorrhœa and aggravated dyspepsia. The cervix was dilated under ether, uterine cavity found to be six and a half inches, curettement was effected and much membrane removed. Recovery was prompt and the reflex symptoms were removed.

Dr. Winn. Many cases come to the hospital with tubes in a somewhat inflamed condition, although not suppurative, and in these cases operation on cervix and curetting is advised as a means of subduing the inflammation, but the precaution is always taken of telling the patient that subsequent laparotomy may be necessary.

Dr. Newton has seen used many different methods of dilating the cervix, rapid dilatation and gradual dilatation, and it would seem to him that the Hagar's dilatation has the advantage of exerting uniform pressure on all parts of the cervical canal.

Dr. Elliott has seen many able gynæcologists use a sharp curette after gradual dilatation and has never seen harm result. Regards this as a method worthy of consideration.

Dr. Boothby regards the word "sharp," as applied to a curette, as a comparative term. All curettes are dull as compared with a knife blade. Described briefly, the dilator used by him with the most satisfactory results.

Dr. Phillips after curettement packs the uterine cavity with gauze for the purpose, as much as anything, of exciting contraction of uterine tissue.

Dr. Powers reported the case of a woman who had borne several children and never in her life menstruated.

Dr. Boothby had seen one case where by reason of the separation of the uteri muscles the uterus was practically outside the abdominal cavity and we had practically a uterine hernia.

This closed the discussion, and it was voted to adjourn the fifty-fourth semi-annual meeting, one of the most satisfactory in the history of the Society. The abundant time afforded for discussion was fully utilized, and the attendance was excellent up to the time of adjournment.

PROCEEDINGS

OF THE

FIFTY-FIFTH ANNUAL MEETING.

APRIL 9–10, 1895.

The fifty-fifth annual meeting was held at the College Building, Tuesday evening, April 9, and at Steinert Hall, Boston, Wednesday, April 10, 1895.

FIRST DAY'S SESSION.

The meeting was called to order at the College Building, East Concord Street, Boston, by the President, John P. Sutherland, M. D., at eight o'clock, and Dr. Lucy C. Hill, chairman presented the

REPORT OF THE COMMITTEE ON OBSTETRICS.

I. Forceps on the Side. Geo. H. Earl, M. D.
II. Tubal Pregnancy and its Treatment. Horace Packard, M. D.
III. Puerperal Convalescence. Duncan MacDougall, M. D.
IV. Pregnancy the Cause of Chorea and Mania. One Case. Ellen L. Keith, M. D.

Discussion opened by Drs. Walter Wesselhoeft, Henry E. Spalding and Maurice W. Turner.

DISCUSSION.

Dr. Walter Wesselhoeft. — The care of extrauterine pregnancy has been largely taken from the obstetrician and placed in the hands of the surgeon. In regard to the use of forceps on the side, it is hoped that others will follow the advice given in the paper on that subject. The facility with which the blades are introduced, the entire control and ease with which traction may be made, are certainly sufficient to recommend the position in all favorable cases, that is, in all cases where no special difficulty is to be met.

In regard to puerperal convalescence there has certainly become prevalent a degree of laxity which bodes ill for the future well-being of mothers. At the same time the opinion may be expressed that the traditional custom of confining a woman in bed until the fundus has returned to its normal size and the lochial discharge has ceased, seems wholly unnecessary. While the observation of all due caution is counselled, there is no hesitation in saying that a much more generous treatment than is customary may be safely allowed, as nature very thoroughly provides for the whole process of involution, and it is reasonable to assume that the relaxed muscular fibres will strengthen all the more readily if brought rationally into play. Involution, it must be remembered, is not merely a mechanical process, it is a vital process, and the more the tone of the system is raised the more will this process be hastened.

Dr. H. E. Spalding. — While accustomed to adapting himself to circumstances in the use of forceps, he must confess he has not found it so easy to use forceps on the side as has been represented. Heartily agrees with Dr. MacDougall in favoring a long puerperal convalescence, and wishes we could prolong it beyond the time usual. While he would not allow a woman to remain constantly in the dorsal position, he cannot agree with Dr. Wesselhoeft that she can get up just as well as not after the third day. Believes that her future health demands that a lying-in patient should have a good long rest.

Dr. Geo. H. Earl.—Can easily understand how one accustomed to using forceps on the back should prefer that position, but cannot but feel that such preference is the result of habit. In his work of instruction in the school he finds that the students more easily acquire proficiency in the use of forceps with the patient on the side.

REPORT OF COMMITTEE ON DISEASES OF CHILDREN.

HELEN S. CHILDS, M. D., *Chairman.*

But one paper was presented in this bureau, entitled

Use and Abuse of Calisthenics in our Public Schools.

Emma J. Peaseley, M. D.

There being no discussion the meeting was adjourned.

SECOND DAYS' SESSION.

The meeting was called to order at 10:30 A. M., at Steinert Hall, by the President, J. P. Sutherland, M. D.

The records of the last semi-annual meeting were read and approved.

The reports of the treasurer and auditor were received and accepted.

Drs. Thomas and French were appointed tellers and the polls were declared open for the election of officers for the ensuing year.

The necrological report was then presented by Henry E. Spalding, M. D.

REPORT OF COMMITTEE ON CLINICAL MEDICINE.

LAMSON ALLEN, M. D., *Chairman.*

Subject: "Water, Therapeutically and Otherwise Considered."

I. The External Use of Cold Water in Pneumonia. Herbert C. Clapp, M. D.
II. Hot Water; Uses and Therapeutics of. D. A. Babcock, M. D.
III. Cold Water; Uses and Therapeutics of. F. A. Gardner, M. D.
IV. Purification of Water, Including Filters. James Krauss, M. D.
V. Bacteriology of Water. J. P. Rand, M. D.
VI. Pollution of Ice. J. K. Culver, M. D.
VII. Wells. N. W. Rand, M. D.
VIII. Contamination of Drinking Water by Lead. J. S. Mitchell, M. D., Chicago, Ill.
IX. Self Purification of Rivers. Lamson Allen, M. D.
X. Clinical Report on Treatment of Diphtheria by Anti-Toxine. William C. Cutler, M. D.
XI. Toxic Amaurosis, with Total Loss of Vision, due to Chronic Lead Poisoning. Frederick W. Payne, M. D.

DISCUSSION.

Dr. Scales endorses the cold pack in pneumonia with the precaution of ascertaining if the compress "warms up" rapidly; if this does not happen the procedure is worse than useless. Thinks that where the cold pack is used the physician should remain with his patient and watch the reaction.

Dr. H. C. Clapp thinks an application of the temperature of 60 degrees cannot do harm. The compresses should be renewed as often as they become dry and hot, in some cases every five or ten minutes. Does not think it necessary to stay by the patient.

Dr. Thomas speaks from personal experience of the efficacy of the cold pack in pneumonia.

Dr. Joseph Chase, having a certain amount of fear of the cold pack, has used warm compresses with good effect. Also uses cotton batting jacket.

Dr. Scales thinks it important to have the wet cloth and dry covering applied together, and not allow the wet compress to remain a minute on the patient without being covered.

Dr. H. C. Clapp gives alcohol to support the heart in cases treated with the cold compress, as he does in others.

Dr. Culver has always found the cold compress of great value. Would suggest the necessity of having an entirely new compress each time to avoid danger from dampness of the outside covering.

Dr. Rand thinks that the beneficial effect of the cold compress is as much due to its action in abstracting blood from the surcharged lungs as in lowering temperature.

At the conclusion of the discussion of the papers presented by this bureau, the following candidates were elected to membership:

Willard C. Stilson, M. D., Winchester.
Walter Tuttle, M. D., Exeter, N. H.
Ella G. Pease, M. D., Boston.
H. Clinton Crocker, M. D., Providence, R. I.
Eugenie M. Phillips, M. D., Somerville.
E. B. Richardson, M. D., Everett.
A. J. Bond, M. D., Adams.
William C. Farley, M. D., Lawrence.
George A. Martin, M. D., Hyde Park.
Forrest Leavitt, M. D., West Somerville.

Then followed adjournment to Hotel Thorndike, where lunch was served to 125 members.

At 2:30, the meeting was again called to order at Steinert Hall, and the President's address, a most able effort, was delivered by John P. Sutherland, M. D.

At the conclusion of the address, Dr. H. C. Clapp moved that the sum of $200 be appropriated for the Hahnemann monument fund.

After remarks by Dr. Clapp and Dr. J. H. McLelland of Pittsburgh, chairman of the Hahnemann monument committee, Dr. N. R. Morse offered as an amendment that the contribution from the Society should be equivalent in amount to one dollar for each of its members. This amendment having been accepted, the motion was carried unanimously.

It was then voted that a committee of three be appointed to solicit from physicians and others in New England, subscriptions to the amount of $2,000 for the same fund. The president appointed as this committee, Drs. Horace Packard, N. R. Morse and H. C. Clapp.

The tellers, reporting through Dr. Thomas, then declared the following officers elected for the ensuing year:

President, Edward P. Colby, M. D., Wakefield.

Vice-Presidents, Frederick B. Percy, M. D., Brookline; N. W. Emerson, M. D., Boston.

Corresponding Secretary, J. Wilkinson Clapp, M. D., Brookline.

Recording Secretary, Frank C. Richardson, M. D., Boston.

Treasurer, Herbert C. Clapp, M. D., Boston.

Librarian, Jane K. Culver, M. D., Boston.

Censors: H. P. Bellows, M. D., Boston; N. Emmons Paine, M. D., West Newton; Horace Packard, M. D., Boston; Alonzo Boothby, M. D., Boston; John P. Sutherland, M. D., Boston.

On motion of Dr. Edward P. Colby, it was voted: "That in accordance with Article X of the By-Laws, the board of censors, by at least one of their members, shall inspect the diploma of each applicant for membership in the Society, or shall make sure of his or her graduation by finding his or her name recorded as a graduate in the catalogue of the college he or she claims as his or her Alma Mater."

REPORT OF COMMITTEE ON INSANITY AND NERVOUS DISEASES.

FRANK C. RICHARDSON, M. D., *Chairman.*

Subject: "Sleep."

I. Physiological Sleep. Edward P. Colby, M. D.
II. Insomnia. D. E. Brownell, M. D.
III. Hypnotic Sleep, with Practical Illustration. James R. Cocke, M. D.
IV. Morbid Sleep. Frank C. Richardson, M. D.
V. Report of Special Committee on Comparative Statistics of Insane Hospitals of Massachussetts.

Presented by J. Heber Smith, M. D.

Owing to the lateness of the hour, the papers of this bureau were not discussed, and it was voted to adjourn to Music Hall, where at 6.30 P. M. the Society united with the New England Hahnemann Association in a grand banquet and literary feast, commemorative of Hahnemann's birthday.

PROCEEDINGS

OF THE

FIFTY-FIFTH SEMI-ANNUAL MEETING

OCTOBER 8-9, 1895.

The fifty-fifth semi-annual meeting of the Massachusetts Homeopathic Medical Society was held at College Building, East Concord St., Boston, Tuesday and Wednesday, October 8th and 9, 1895.

FIRST DAY'S SESSION.

The meeting was called to order by the President, E. P. Colby, M. D.

REPORT OF THE COMMITTEE ON GYNÆCOLOGY.

JANE K. CULVER, M. D., *Chairman.*

I. A Case of Ectopic Pregnancy. J. K. Warren, M. D.

After outlining the diagnostic points of tubal pregnancy at the various periods, and the usual location of ectopic gestation, Dr. Warren reported a most interesting case, which necessitated operation, and the patient recovered.

DISCUSSION.

Dr. Horace Packard from his experience thinks rupture is likely to take place from six to eight or ten weeks, and the result is most likely to be serious when rupture takes place downward, and fœtus lodges in fold of broad ligament, and fœtus lives several months.

The question of operation is an important one. Where rupture is upward into peritoneal cavity, and there is hemorrhage, there can be no question of the necessity of an operation. If in broad ligament, should consider the use of electricity.

The question of disposition of the placenta is an important one, as it is an exceedingly hemorrhagic tissue.

Dr. Colby suggests the advisability of preparation for immediate operation, when about to use electricity, for fear of the electricity precipitating rupture.

Dr. Packard feels that it might be well to, at any period, destroy the fœtus by electricity, and then resort to surgical operation.

Dr. Boothby congratulates Dr. Warren upon the successful conduct of his case. Has very little confidence in electricity for the treatment of extra uterine pregnancy.

The careful introduction of ligatures beneath the placenta, will in most cases, obviate the danger from hemorrhage, which has been dwelt upon.

The great difficulty is in recognizing nature of case early.

II. Cystitis, Following Pregnancy. George E. Percy, M. D.

The author reviewed the theory of microbic origin of cystitis. That bacteria may be an etiological factor is entirely possible, but that it is the sole cause, is a theory which to the author's mind is untenable.

Mention was then made of the treatment, locally and by systemic medication. Thinks that local treatment should never be neglected. For relief of the spastic obstruction to urination, knows of no drug more promptly palliative than opium.

Chimaphilla is also a drug of the greatest possible use in relieving the strangury, etc.

III. Treatment of Uterine Displacements, other than Surgical.
Mary E. Mosher, M. D.

The author reviewed the variations from normal position of uterus, and dwelt upon the various causes of uterine displacement.

Then discussed the etiology, symptomatology, and treatment of retroversion, recommending among other preventative treatment, the wearing of abdominal bandages after parturition until relaxed ligaments can support uterus.

Fer. Iod., Sepia. and Nux. Massage after inflammatory symptoms. Electricity, tampons. Pessaries sometimes necessary, but other means are usually sufficient. Dwelt upon the difficulty in properly fitting pessaries.

Surgery only as a last resort and reported a case for correction of displacement which resulted disastrously three years later, when during a pregnancy she suffered, and finally labor began with convulsions and a half-grown child was turned and delivered. Six months later similar occurrence.

DISCUSSION.

Dr. Lamson Allen questions the advisability of abdominal bandage. Has never used bandage and has yet to find a patient who has suffered from non-use of it, and considers it mal-practice to use it. When labor is completed distended abdominal muscles are not contracted by bandages, but on the contrary by disuse remain relaxed.

Dr. Stone condemns the practice of some physicians of giving a patient pessary to put in place herself when she feels the need of it.

Dr. Mosher. Have seen serious result from this very thing.

Dr. Boothby. Have never heard of such a preposterous thing. Should as soon think of giving a woman a knife to perform a laparotomy on herself. Ventral fixation is not desirable during child-bearing period.

Dr. Packard. In treatment of retro-displacements. Why do they occur in young women? Believes it to be due largely to improper mode of dressing. Hanging heavy weight of clothing from hips.

Dr. Colby. If pessary fits tolerably well, patient becomes as addicted to it as a toper to his drink, and it is most impossible to get her to give it up.

IV. The Conservative Side. Jane K. Culver, M. D.

After reviewing the early history of gynæcology, the author made an earnest plea for the use of conservative methods, before resorting to the surgical procedure so popular at the present day.

REPORT OF THE COMMITTEE ON OPHTHALMOLOGY, OTOLOGY, RHINOLOGY AND LARYNGOLOGY.

JOHN H. PAYNE, M. D., *Chairman*.

I. The Curative Action of Certain Remedies in Diseases of the Upper Respiratory Tract. George B. Rice, M. D.

Author gave characteristics of three leading remedies in naso-pharyngeal catarrh. Calc. Carb., Calc. Iod., and Calc. Phos.

There is another class of cases confined to nasal passages, due to some form of hypertrophic rhinitis; here internal remedies can do no good without previous surgical interference. Lobel. Cerel., Kal. Bi., and Hydras. Merc. for hypertrophic rhinitis.

Still another class of cases, atrophic rhinitis of non-syphilitic origin. These cases cannot be cured by indicated homeopathic remedy. The frequent cleansing, douching, etc., is the only means of treatment. Aurum Met., Sepia., Silica., Sulph.

II. Mental Astigmatism. L. Houghton Kimball, M. D.

Dr. Klein. — Errors of refraction caused aberration of ideas, causing errors in color-perceiving function.

Dr. Winthrop T. Talbot spoke of effect of astigmatism upon individual styles of artists in their work. The outwardly projected image must correspond with image received upon retina and impressed upon the cortex.

III. Localization of Brain Centres Controlling Motion of Ocular Muscles. E. L. Mellus, M. D.

IV. A New Clinical Symptom of Petroleum Confirmed.
J. H. Payne, M. D.

SECOND DAY'S SESSION.

An interesting Surgical Clinic was held at the Massachusetts Homeopathic Hospital from 9 to 10 A. M., under the direction of Dr. Horace Packard.

Meeting called to order at College Building at 10 A. M. by the President, Edward P. Colby, M. D.

Records of last annual meeting read and approved.

Dr. N. R. Morse suggests that the Society secure a permanent meeting place.

Candidates elected to membership:

Nelson M. Wood, M. D., Charlestown.
Thomas W. Green, M. D., Chelsea.
Helen G. F. Mack, M. D., East Boston.
Henry F. Batchelder, M. D., Danvers.
Ida Dudley Clapp, M. D., Roxbury.
Roland A. Davis, M. D., Somerville.
Mary S. Hornby, M. D., Roxbury.
Emily Jones Barker, M. D., Wellesley.

REPORT OF THE COMMITTEE ON SURGERY.

J. EMMONS BRIGGS, M. D., *Chairman.*

I. A Report of Five Consecutive Surgical Cases. Alonzo Boothby, M.D.

Experience has proved that the idea that the summer months are unfavorable to operations is a popular fallacy. The doctor then reported at considerable length five interesting cases.

CASE 1. — Woman, 25 years old, had for few months noticed enlargement of abdomen; the local physician had diagnosed ovarian tumor. Dr. Boothby's examination left diagnosis in doubt. On opening

abdomen a large dermoid cyst, consisting of hard, almost bony tissue. Patient made uneventful recovery.

CASE 2. — Patient, 55 years old, almost moribund, had acute peritonitis for about ten days, large amount of fluid in abdominal cavity, and a tumor (fibroid 15 lbs.) which had begun to degenerate. The tumor was enucleated from its adhesions, the pedicle ligated, including ovaries and tubes. The patient has steadily improved, and convalescence uneventful. Had had tumor about thirty years.

Illustrates the common occurrence of allowing fibroids to go on till they break down and frequently cause death by septic peritonitis. Five times as many die this way as from properly conducted operation.

CASE 3. — Similar to the preceding.

CASE 4. — Had noticed enlargement three or four years, menorrhagia for long time. For three months previous to operation the hemorrhage had been almost continuous.

In this case there had been much adhesive inflammation, which complicated the operation. The tumor presented a dark, grayish, infiltrated mass, almost like a sarcoma; but the malignancy is doubtful. This was a complete extirpation. Patient is progressing favorably, and is now sitting up. The recovery has been slow, owing to debilitated condition of patient prior to operation.

CASE 5. — Cyst of left broad ligament, and necessitated simple operation with uneventful recovery.

DISCUSSION.

Dr. Warren does not feel like criticising a series of cases of so serious character which was conducted so successfully. Spoke of the advantages derived from a private hospital.

As to the advisability of operating on fibroids. If there are signs of cystic degeneration or inflammatory action there can be little question as to the advisability. If no inflammation and the patient is enjoying good health, should advise leaving alone.

Question of treating pedicle externally, my own preference is to close abdominal cavity whenever possible.

In regard to drainage tube, thinks it impossible to keep tube clean, and is a frequent source of septic infection. Wash out cavity thoroughly and close it. Much more danger from tube than from anything which may be left after a carefully conducted operation.

Dr. Boothby thinks matter of temperature can be controlled much better in summer than in winter. July and August much better to operate in than February and March and if operation can be postponed to former period.

Should be glad to close up every abdominal cavity if could be sure that absolutely no septic matter has been left. It is impossible to wash out so as to be absolutely sure of asepsis.

Less danger in tube than in running the risk of septic infection from retained septic matter.

II. A Review of Cranial and Cerebral Surgery, with Report of Cases. Horace Packard, M. D.

The paper comprised introductory considerations of present status of Cranial and Cerebral Surgery, continued with remarks on the technique of operation with description of instruments most in use. A brief review of fracture of the skull illustrated by report of case of fracture left side of skull with depressed bone. Operation was at once undertaken with relief of symptoms. Three other cases of fracture were reported illustrative of the methods used.

Removal of bullet from frontal sinus with prompt recovery.

Operations upon brain and meninges were then taken up and cranial topography explained.

DISCUSSION.

Dr. E. L. Mellus wished to heartily endorse the paper and reviewed briefly the advances made in cerebral localization.

Dr. Winfield Smith reported case of trephining for epileptic seizures resulting in complete relief.

III. An Operation for the Radical Cure of Hemorrhoids. N. W. Emerson, M. D.

Author described a new and successful operation for the radical cure of hemorrhoids.

IV. Further Experience in Colotomy. F. W. Halsey, M. D.

DISCUSSION.

Dr. W. F. Wesselhoeft exhibited a case of colotomy wound, recovery being good and relief perfect.

The Annual Oration was delivered by N. W. Rand, M. D., after which a collation was served.

AFTERNOON SESSION.

REPORT OF THE COMMITTEE ON MATERIA MEDICA.

CHARLES L. NICHOLS, M. D., *Chairman.*

I. A Plea for Pure Homeopathic Materia Medica. A. M. Cushing, M.D.

II. Poisoning by Playing the Flute. J. Heber Smith, M. D.

Reported a most interesting case of poisoning from playing a flute made of Cocus wood.

1-2000 Sol. Nitrate of Lead as local application gave immediate relief.

The Cocus-wood or Grenadille, of Cuba and South America, has for years been employed for the manufacture of flutes, and seems to possess a peculiar virulence. In this case the manifestation consisted of an obstinate swelling and redness of the lip, on which were many patches of inflamed skin covered with watery vesicles.

DISCUSSION.

Dr. E. D. Fitts spoke of the extreme susceptibility of some people to poisoning by various agencies. As an illustration quoted his personal susceptibility to Rhus poisoning and to attacks of urticaria following eating fish.

The thought occurs, whether a proving occurring in a person so susceptible, is of value and how is it possible to decide whether the symptoms aroused may not be due to some latent condition.

III. A Clinical Study. Cases of Neurotic Constipation.
Conrad Wesselhoeft, M. D.

A serious and generally chronic neurosis having its seat in the sympathetic nervous system of nerves and usually involving the cerebral functions in the form of hypochrondriasis, the latter usually associated with neurasthenia and sometimes with hysteria.

DISCUSSION.

Dr. Sutherland endorses the use of large quantities of water. Also large doses of olive oil which is not absorbable and is inter-mixed with the fœcal matter in intestinal tract.

In the matter of adjuvants mentions massage, rolling with ball of shot, and electricity.

In deficient peristalsis small doses of ox gall will prove beneficial by physiological action.

Drugs sometimes useful but the majority of cases cannot be cured without the use of adjuvants. Nux. Vom., the most popular remedy is not nearly so often indicated as Opium, Plumbum, etc.

IV. Acetic Acid in Malignant Growths. F. B. Percy, M. D.
V. A Fragment on Calcic Iodide. Chas. L. Nichols, M. D.

Reported cases of tumors reliably diagnosed as malignant which have disappeared under the use of Calcic. Iod., 3 X., 2 grains, four times a day.

These call attention to two points, that certain tumors of the breast are curable, 2nd. that Cal. Iod. has a definite use in this connection. Does not wish to be understood as wishing to detract in any way from the brilliant record of the knife in early stages of cancer, which cannot be excelled by any known means. Is inclined to regard his cases as of fibroma and cystic fibroma.

REPORT OF COMMITTEE ON DERMATOLOGY, SYPHILOLOGY AND GENITO-URINARY DISEASES.

S. H. BLODGETT, M. D., *Chairman.*

I. A Suggestion. J. W. Hayward, M. D.

In his paper the author suggested an improvement in the technique of Duplay's operation for hypospadias. Suggests the use of the well-known shoe-maker's stitch, and thinks that by its use may be avoided the sphacelation of the tissues which is not uncommon when old methods are followed.

II. Superficial Epithelioma. John Lambert Coffin, M. D.

After describing graphically superficial epithelioma and its etiology, expressed belief that early removal will give favorable prognosis.

Then mentioned the various caustic pastes. Thinks well of daily application of Fowler's solution.

III. Urethral Stricture. Orrin B. Sanders, M. D.

After reviewing the symptoms of various forms of urethral stricture, spoke especially of sequellae of organic stricture. Discussed the question of calibre of normal urethra and spoke of difficulty of following any of the arbitrary scales like Otis' or White's. Then detailed the various methods of remedying stricture, including dilatation gradual and immediate, internal and external urethrotomy. Foremost should be mentioned electrolysis, this to the mind of the author is the method for all severe cases and steel sound for dilatation.

IV. Scarlet Fever in Obstetrical Cases. A. H. Powers, M. D.

The author thinks the popular dread of scarlatina in lying-in cases arises from the confusion of the scarlatina eruption with that occurring as an accompaniment of septicæmia.

Adjourned.

PROCEEDINGS

OF THE

FIFTY-SIXTH ANNUAL MEETING.

APRIL 8, 1896.

The fifty-sixth annual meeting of the Massachusetts Homeopathic Medical Society was held at Steinert Hall, Boston, Wednesday, April 8, 1896.

The meeting was called to order by the President, Edward P. Colby, M. D.

After the reading and approval of the records of the last meeting, the reports of the treasurer and auditor were received and accepted.

Dr. Frederick A. Warner, necrologist, presented interesting biographical sketches of the late Dr. D. B. Whittier and the late Dr. Lewis Whiting, which were supplemented by eulogistic remarks on Dr. Whittier, by Dr. N. R. Morse.

The following candidates were then elected to membership, having been approved by the Board of Censors and recommended by the Executive Committee:

S. B. Elliot, M. D., Boston.
Edwin A. Knight, M. D., West Newton.
Florence N. Robinson, M. D., Lawrence.
John Dike, M. D., Melrose.
Annie Louise Farrington, M. D., Cambridge.
Edgar P. Fisher, M. D., Winchester.
Horace M. Paine, M. D., West Newton.

At 10.30 o'clock A. M. the President appointed Drs. French and Wood as tellers, and declared the polls open for the election of officers for the ensuing year.

REPORT OF THE COMMITTEE ON CLINICAL MEDICINE.

WALTER WESSELHOEFT, M. D., *Chairman.*

I. Some Anatomical Anomalies of the Heart.
John P. Sutherland, M. D.
II. Angina Pectoris. J. P. Rand, M. D.
III. Report of Autopsy of Case of Septic Endocarditis.
F. P. Batchelder, M. D.
IV. A Case of Septic Endocarditis, with Clinical Remarks.
Walter Wesselhoeft, M. D.

DISCUSSION.

Dr. N. R. Morse could not fully endorse Dr. Rand's treatment of angina pectoris. Feels that much care should be taken not to alarm the patient during an attack. Believes that much may be done by the indicated remedy which may be Acon., Spigelia, Bromine. Amyl Nit. may sometimes relieve. Does not think tobacco will cause angina pectoris but would not advise its use by those subject to this affection.

Dr. Sherman was reminded by the discussion of the case of our late colleague, Dr. L. D. Packard, where Amyl Nit. was used without result. Believes that tobacco should not be used by patients with heart disease.

Dr. Eaton believed fully in the favorable influence of remedies on valvular heart disease, and reported a case of mitral regurgitation supposed to have existed for fifteen years, in which the physical signs disappeared entirely after two months' use of remedies. The principal remedies used were Kal. Lat., Laurocerasus, and Naja.

REPORT OF THE COMMITTEE ON OBSTETRICS.

GEO. H. EARL, M. D., *Chairman.*

Subject: "Puerperal Infection."

I. Varieties, Symptoms and Causes. Emma J. Peaseley, M. D.
II. Therapeutics. John J. Shaw, M. D.
III. Surgical Treatment. H. E. Spalding, M. D.
IV. General Treatment, with Report of Cases. Geo. H. Earl, M. D.

DISCUSSION.

Dr. Morse has found Arsen. Alb. a most excellent remedy in puerperal septicæmia.

Dr. Mary Mowry Pearson spoke of the advantages to be derived from the use of the finger as a curette.

Adjourned at 1 P. M. for luncheon at Hotel Thorndike.

AFTERNOON SESSION.

The meeting having again been called to order, the President's address was delivered by Edward P. Colby, M. D., and was an extremely able and thoughtful essay, touching upon many points of vital importance to the cause of homeopathy in New England, and containing valuable recommendations.

After some discussion it was voted that if deemed advisable by the executive committee, the next semi-annual meeting should be held at Worcester.

The special commission, appointed by the executive committee, to investigate the adverse criticisms of the State Board of Lunacy and Charity upon the Westboro' Insane Hospital then presented, through Dr. John P. Sutherland, a lengthy report embodying the results of their investigations, as proving conclusively that the statements made by the State Board in its last Annual Report have no foundation in fact; on the contrary the special commission finds every reason to most heartily endorse the institution and its management.

Their report gave rise to considerable spirited discussion of the methods of the State Board of Lunacy and Charity, many members expressing in emphatic terms their indignation and disgust at such prejudice and incompetency as is constantly exhibited by said board.

It was finally voted that future action in regard to the matter be left entirely to the discretion of the executive committee.

REPORT OF COMMITTEE ON DISEASES OF CHILDREN.

N. R. PERKINS, M. D., *Chairman.*

I. A Case Simulating Acute General Tuberculosis, with Secondary Meningitis. N. L. Damon, M. D.

II. The Necessity for the Early Examination of the Eyes of School Children. A. E. Perkins, M. D. Discussion opened by G. A. Suffa, M. D.

III. A Case. N. R. Perkins, M. D.

As a result of the ballot, the tellers announced the election of the following officers:

President, Frederick B. Percy, M. D.

Vice-Presidents, H. P. Bellows, M. D.; N. W. Rand, M. D.

Corresponding Secretary, J. Wilkinson Clapp, M. D.

Recording Secretary, Frank C. Richardson, M. D.

Treasurer, H. C. Clapp, M. D.

Librarian, Samuel Calderwood, M. D.

Censors, Conrad Wesselhoeft, M. D.; Alonzo Boothby, M. D.; E. P. Colby, M. D.; N. Emmons Paine, M. D.; Horace Packard, M. D.

REPORT OF THE COMMITTEE ON INSANITY AND NERVOUS DISEASES.

JAMES F. BOTHFELD, M. D., *Chairman.*

I. A Report of Three Unusual Cases of Nervous Disease, together with Remarks on their Clinical Management. James R. Cocke, M. D.

II. Modern Care of the Insane. Ellen L. Keith, M. D.

III. Curability of Insanity. George S. Adams, M. D. Discussion opened by N. Emmons Paine, M. D.

IV. A Case of Myxœdema. Edith C. Varney, M. D.

V. The Importance of Early Diagnosis of General Paresis. James F. Bothfeld, M. D.

DISCUSSION.

Dr. N. Emmons Paine described the method of committing insane patients to the various hospitals of the State. Claims emphatically that the remarkable superiority of the results obtained at Westboro is due to medication and the use of the rest cure.

Adjourned.

PROCEEDINGS

OF THE

FIFTY-SIXTH SEMI-ANNUAL MEETING.

OCTOBER 14, 1896.

The fifty-sixth semi-annual meeting of the society was held at Worcester, Wednesday, Oct. 14, 1896.

The meeting was called to order at 10 : 30 A. M., by the President, Frederick B. Percy, M. D.

The records of the last meeting having been read and approved, the following candidates were elected to membership :

Carl Crisand, M. D., Worcester.

George W. Haywood, M. D., Lynn.

The President then introduced, as a delegate from the Maine Homeopathic Medical Society, Dr. Hanscom, of Rockland, Maine, and also Dr. W. H. Weeks, of East Harwich, as delegate from the Vermont Homeopathic Medical Society.

Dr. Percy, in behalf of the committee appointed to investigate and controvert the charges made against Westborough Insane Hospital, made a brief verbal report of progress, which was accepted and the committee continued.

Dr. Winthrop T. Talbot, with explanatory remarks, moved that a committee of five, composed of three representatives of the medical profession and two of the law, be appointed by the president to investigate the subject of the regulation of medical expert testimony in the state of Massachusetts. Carried.

The President appointed on this committee Walter I. Badger, Everett W. Burdett, and Drs. Horace Packard, W. T. Talbot, Frank C. Richardson.

REPORT OF THE COMMITTEE ON SURGERY.

J. K. WARREN, M. D., *Chairman.*

I. Cystoscopy and Ureter-Cystoscopy. James Krauss, M. D.

Dr. Krauss, in paper entitled "Cystoscopy and Ureter-cystoscopy," explained the construction of the cystoscope, which instrument was exhibited to the society. He described its use and the advantages to be derived from it, giving an interesting and instructive description of normal and pathological tissue as it appears through this instrument.

DISCUSSION.

Dr. Whitmarsh complained that one cystoscope which he had used generated so much heat as to render the patient very uncomfortable.

Dr. Krauss said that this trouble was easily remedied by temporarily shutting off the current.

II. A somewhat Complicated Cœliotomy. Winfield Smith, M. D.

Dr. Winfield Smith reported a cœliotomy performed under the most unpromising circumstances, and yet followed by perfect recovery. The author wished to emphasize the deduction that the most untoward and gravest symptoms should not deter the surgeon from making the effort to save life.

III. Amputations at the Hip Joint. Horace Packard, M. D.

Dr. Horace Packard, after explaining the original Wyeth's method of bloodless hip joint operation, illustrated his modification thereof by the report of a case of hip joint amputation made necessary by the ravages of osteo-myelitis. By introducing one pin in front so as to pass between the bone and blood vessels, the vessels were compressed by winding a ligature about these tissues. The posterior pin was passed beneath the gluteal vessels which were in turn compressed by ligature. The remaining tissues were uncompressed. The author had found that this modification greatly facilitated the operation.

DISCUSSION.

Dr. Winfield Smith spoke of the greatly improved methods of amputation by reason of which it is now possible to make a very favorable prognosis of these cases.

IV. Cancer of the Rectum. A Case. J. K. Warren, M. D.

Dr. J. K. Warren in his paper laid stress upon the importance of early diagnosis and immediate and thorough extirpation of cancer of the rectum. He illustrated his point by the report of a case of this most distressing malady upon which he had operated successfully, and showed the pathological tissue removed.

DISCUSSION.

In reply to question by Dr. Rand, Dr. Warren said that the patient had become able to control the fæcal movements by means of the accessory muscles, the sphincter having been necessarily removed.

Dr. Winfield Smith agreed with Dr. Warren in advocating the radical operation before making colotomy.

Before closing the Bureau, Dr. Warren announced that at last Worcester has a homeopathic hospital. Through the generosity of a lady resident, land and building have been provided and the hospital is fairly launched on its career.

At 12.30 the meeting adjourned for lunch, to reassemble at 1 P. M., at which hour was presented the

REPORT OF THE COMMITTEE ON OPHTHALMOLOGY, OTOLOGY, RHINOLOGY, AND LARYNGOLOGY.

HOWARD P. BELLOWS, M. D., *Chairman.*

I. The Prevention of Deafness. J. M. Barton, M. D.

Dr. J. M. Barton urged the importance of prompt attention to acute affections of the ear, giving concise indications for the use of homeopathic remedies in the various forms of ear trouble.

DISCUSSION.

In reply to a question Dr. Barton said that for the purpose of removing hardened wax from the ear it is his custom to use first an injection of warm solution of bicarbonate of soda. If this is not effective and the wax is much hardened, he uses a mixture of olive oil or almond oil with ether. This shrinks the wax and makes it easy of removal.

Dr. Cushing has found that dropping fluids into the ear frequently causes cough, and he has wondered if some coughs might not have their origin in ear trouble.

Dr. Barton, in reply to question, said that the use locally of acetanalid has relieved troublesome itching in the ear.

II. Report of a case of Tuberculous Laryngitis, and a Case of Empyema of the Maxillary Sinus. George B. Rice, M. D.

Dr. George B. Rice reported a case of tuberculous laryngitis with exhibition of the larynx removed post-mortem. Also a case of empyema of maxillary sinus following the extraction of a tooth.

DISCUSSION.

Dr. Batchelder had been especially interested in the specimen of larynx exhibited by Dr. Rice. We find in this specimen an illustration of how the epithelial cells deviate from the normal as a result of

disease. It also illustrates the tendency of the invasion downward and toward the median line. Feels that Dr. Rice was justified in diagnosing tuberculosis, even though the microscope did not at first substantiate it.

Dr. Martin, of Lowell, reported a case of pus accumulation in the antrum.

III. The Treatment of Granulating Surfaces at the Ear Clinic in Halle. Howard P. Bellows, M. D.

In this paper Dr. Howard P. Bellows gave a most interesting description of the methods in vogue at this clinic and commented upon the excellent results obtained.

REPORT OF THE COMMITTEE ON GYNÆCOLOGY.

ALONZO BOOTHBY, M. D., *Chairman.*

I. Present Status of Gynæcological Electro-Therapeutics. Frank C. Richardson, M. D.

In this paper the author reviewed the modern methods of using electricity in gynæcological practice, and claimed the successful application of this agent had been an important factor in restoring a healthy conservatism in the treatment of diseases of women.

To achieve success with this therapeutic method the physician must not only be a skilled gynæcologist, but must possess a thorough knowledge of electricity and employ scientifically constructed apparatus.

DISCUSSION.

In reply to question, Dr. Richardson said that the positive pole was used to control hemorrhage in cases of fibroid.

Dr. Batchelder wished to inquire if in the opinion of the author electricity could be relied upon to control all uterine hemorrhage caused by fibroids.

Dr. Richardson, from an experience with a considerable number of cases, believes that in the majority of cases the galvanic cauterization will check the hemorrhage. Has heard of failures, but believed them due to insufficient current strength. Considers that a current of seventy milliampères and over is necessary for satisfactory result.

Dr. Southwick has for ten years used electricity in gynæcological practice, and values the agent highly. Wished to fully indorse the paper. To get best results from gynæcological electro-therapeutics one must have not only a thorough knowledge of electricity, but also be expert in diagnosis. Thinks it is of undoubted value in treatment of fibroids, but has met cases where it did no good. It will not always stop hemorrhage. Does not believe in puncture.

In regard to the current of sedation, thinks the faster the vibrations

the more sedative the effect. Is in the habit of using electricity in conjunction with the ordinary local treatment. Thinks the cheap, portable batteries with which the market is crowded are of no use in gynæcology. Would lay particular stress upon the importance of rest after electrical treatment.

II. The Treatment of Abortion. George R. Southwick, M. D.

Dr. Southwick gave an exhaustive résumé of the modern methods of conducting abortions at the various periods of pregnancy, paying especial attention to the various aseptic and antiseptic measures in vogue, and urging that the uterus should be carefully but thoroughly emptied of its contents.

DISCUSSION.

Dr. A. M. Cushing thinks the majority of these cases get well, asepsis or no.

Dr. J. H. Sherman thinks that, where there exists any doubt as to the complete expulsion of the uterine contents, a specialist should be called, and the womb properly cleaned out.

Dr. E. P. Colby reported a complicated case of abortion where there were twins. After the first fœtus came away, extracted the second fœtus and first placenta, the second placenta being retained till after fever had developed. Urges thorough examination to make certain that everything has come away.

Dr. Cate advises to clean out the womb at once.

Dr. Cushing thinks the finger is the best curette, and that we can rely a good deal on medicine.

Dr. Moore reported a case where during the past six years the patient has three times been delivered of a dead fœtus, which in each case has died about six weeks before full term. She is now pregnant again, and it is a matter of interest to see if her former experience will be repeated.

Dr. Rand spoke of a case of abortion where the patient made a prompt recovery, but six weeks after there came away a piece of placenta as large as a hen's egg.

Dr. Packard dislikes to hear remarks similar to those of Dr. Cushing's. Of course, we must believe that, as Dr. Cushing says, in his cases the fœtus dies, the womb throws off its contents, and nature completes a cure. But this is a matter for personal congratulation rather than an argument against the modern methods of prompt aseptic evacuation of the uterine contents. Must insist that asepsis and antisepsis are matters of the greatest possible importance in the conduct of these cases. By the use of these precautions it is possible to terminate the case quickly and safely without having to wait for nature.

Dr. Cushing was glad to hear Dr. Packard's criticism, and had only to say in reply that he had been taught to make use of homeopathy and in a long practice had never lost a case of abortion.

Dr. Winfield Smith questioned the necessity for packing the uterine cavity. Believed that if the curetting was thoroughly done and carried down to healthy uterine tissue as it should be, the hemorrhage would cease.

Dr. Powers commended the finger as a curette. Thinks we should be cautious as to the use of iodine, carbolic acid, etc., especially if the inflammation has extended to the body of the womb, as in these cases the sealing up, as it were, of the uterine cavity by these agents was dangerous.

Dr. Fred L. Emerson cited a case of abortion illustrating the value of antiseptic treatment in even unpromising cases. After five weeks of severe flowing, interference was finally allowed and a large quantity of fœtid tissue was removed, after which the patient made rapid recovery.

Dr. Hanscom spoke of a case of criminal abortion, partial delivery, and profuse hemorrhage. In addition the patient had a large fibroid. Asepsis, curetting, and intrauterine douching brought about recovery.

Also spoke of a death resulting from perforation into the peritoneal cavity by a knitting needle, used in an attempt to induce abortion.

Dr. J. Heber Smith considers that internal medication is most useful in controlling hemorrhage in the early months. Has found the application of heat over the lumbo-sacral region to be very effective in producing uterine contraction reflexly. Spoke of the danger of infection from catheterization, and has been able to relieve post-partum retention by flushing the rectum with hot water. Reported a case of double uterus.

Dr. Southwick discussed the question of packing the uterine cavity in cases of hemorrhage. Usually the rapid and thorough evacuation of the uterine contents would stop the bleeding, but not always. As an illustration of intractable hemorrhage, told of a case where the patient already exsanguinated by hemorrhage incident to abortion came under his care. The uterus, which was large with narrrow cervix, was emptied but the hemorrhage did not cease. The blood seemed watery and did not clot. Intrauterine douches of hot water seemed to check the bleeding and the womb was packed with gauze. Six hours later patient started flowing again, and in spite of repeated packings, the use of styptics, etc., the patient became so weak from loss of blood that it was necessary to resort to stimulants and saline injections. The hemorrhage was finally controlled by swabbing the uterine cavity with iodine, and the patient made a slow recovery. In this case the excessive hemorrhage was probably due to the fact that the blood had lost its coagulating property.

Does not believe that the use of carbolic acid and iodine "seals up the uterine cavity," as Dr. Powers had intimated.

III. The Faradic Current in Diseases of the Uterus.
Clara E. Gary, M. D.

As the time allotted the Bureau had expired, Dr. Gary's paper was not discussed.

REPORT OF THE COMMITTEE ON MATERIA MEDICA.
N. W. RAND, M. D., *Chairman.*

I. Phaseolus, the New Heart Remedy. A. M. Cushing, M. D.

In this paper Dr. Cushing gave a detailed report of symptoms occurring during a proving of this remedy, and argued therefrom that it should be a valuable drug in the treatment of cardiac affections.

DISCUSSION.

Dr. H. C. Clapp has used phaseolus in three cases of heart disease accompanied with dropsy, and in all three the result was negative. Used a decoction of the pods first, and afterward the whole bean freely.

Dr. Cushing uses the best white beans.

II. An Analysis of Bryonia. E. D. Fitch, M. D.

Dr. Fitch gave a most complete analysis of this drug, following the concordance method.

DISCUSSION.

Dr. J. Heber Smith wished to commend most heartily the paper. Believes in the value of drug analysis by this method. Does not insist upon his students committing to memory the raft of symptoms found in the text-books. Rather seeks to have them acquire a knowledge of the sphere of action of the drug.

Dr. Barton spoke of the frequent confirmation of the Bry. indication, "pain increased by lying on the painful side and aggravated by motion." Has found the drug of especial value in constipation, due to the prolonged use of opium and its derivatives.

Dr. Lamson Allen criticised the concordance method as eminently unsatisfactory, as, indeed, are all methods so long as provings are not made scientifically. We must, for example, know first of all that the prover is in a perfectly healthy condition before taking the drug.

Dr. N. W. Rand, in giving Bry. for cough, has learned to rely upon the aggravation by heat.

Dr. J. Heber Smith. As a rule the more poisonous the drug the more valuable it is as a remedy; still there are many remedies sup-

posed to be inert, upon which we have learned to depend. Phaseolus, recently discussed, may be one of these. We certainly need to study the human system more thoroughly, even if we have to let the proving go. We must not educate our patients to think that everything that happens to them after taking a pill is necessarily due to that pill.

Dr. Rand. What we want to know is what a drug will do to the average person, not its action upon some one individual with inevitable idiosyncrasies.

III. Rectal Symptomatology. H. E. Spalding, M. D.

IV. Aletris Farinosa, a Type of the Vegetable Bitters; Their Value.
J. Heber Smith, M. D.

Dr. J. Heber Smith in this paper gave a most interesting and instructive résumé of the sphere of action of this class of remedies, dwelling especially upon the indications for Aletris Farinosa.

Time would not admit of the discussion of this paper.

After the close of the Bureau, Dr. J. P. Sutherland exhibited and explained a new electric centrifuge, manufactured and sold by Otis Clapp & Son. Of the various centrifuges on the market, Dr. Sutherland considers this the most practical and useful. For the purpose of securing urinary sediments, or the separation of blood constituents, it will be found invaluable.

REPORT OF COMMITTEE ON DERMATOLOGY, SYPHILOLOGY AND GENITO-URINARY DISEASES.

JOHN LAMBERT COFFIN, M. D., *Chairman.*

I. The Extra-Genital Primary Lesson of Syphilis.
John Lambert Coffin, M. D.

Discussion opened by Winfield Smith, M. D.

This was an exposition of the frequent occurrence of syphilis innocentia. The paper spoke of the many and varied sources of infection, and entered a plea for some measure tending to the restriction and control of syphilis in this country. The author does not agree that the registration of prostitutes legalizes prostitution; it is simply legal recognition of the evil, and recognition of it is the first step towards its correction.

DISCUSSION.

Dr. Winfield Smith. The prevalence of syphilis in this country emphasizes the necessity for some preventative measures. During the past few years the spread of this disease in America has been alarming, and there is imperative call for drastic suppressive measures. It is a surprising fact, which I learned on good authority, that

syphilis is at the present time almost unknown in Rome and Naples. The general opinion of the Italian observers, explanatory of this fact, is that at some time, more or less remote, the progenitors of the present Neapolitans and Romans became infected and have transmitted the disease down along the line until the present generation is immunized, as it were, by an attenuated virus. Spoke of the marked favorable effect upon these secondary manifestations of syphilis of physiological doses of the iodides.

II. Lupus Vulgaris. A. H. Powers, M. D.

Dr. Powers reviewed the modern views, as to etiology, diagnosis, and treatment of this disease, and illustrated his remarks by report of cases.

DISCUSSION.

Dr. Packard spoke of a case of lupus unusually situated on the calf of the leg.

Dr. Coffin advocates early operation upon lupus.

Dr. Nichols reported a case of lupus on the neck of fifteen years' duration. It was operated upon three years ago, and there has been no return.

Dr. Coffin spoke of the use by Crocker, of London, of tuberculin in the treatment of lupus. Although it had been acknowledged to be a failure as a curative agent, its administration had seemed to produce considerable favorable effect.

The constant application of phosphorus has seemed to retard the progress of lupus.

Dr. Winn reported a case of relapse after six years' immunity.

By vote of the Society, the President appointed the following committee to take some action looking toward the restriction of syphilitic infection in America: Drs. Smith, Coffin, Powers, Colby and Nichols.

At 6 P. M. the banquet was served. Excellent music, furnished by an orchestra and male quartet, enlivened the occasion.

As an introduction to the post-prandial exercises, the orator, Dr. William F. Wesselhoeft, read a most interesting and learned essay.

This elicited a vote of thanks to the author. Brief remarks by Dr. Fitch, President of the Worcester County Society, and others concluded the exercises, and the society adjourned.

The attendance throughout the day was good, the discussion scientific and dignified, and the experiment of holding an occasional meeting in other cities than Boston seemed a success.

PROCEEDINGS

OF THE

FIFTY-SEVENTH ANNUAL MEETING.

APRIL 14, 1897.

The Fifty-seventh Annual Meeting of the society was held at Steinert Hall, Boston, Wednesday, April 14, 1897.

The meeting was called to order at 10 A. M., by the President, Frederick B. Percy, M. D.

After the reading and approval of the records, reports of the Treasurer and Auditor were received and accepted.

The report of the Necrologist, F. A. Warner, M. D., was presented and referred to the committee on publication.

The following candidates were then elected to membership:

Allen D. Hammond, M. D., Brockton.
Geo. Forrest Martin, M. D., Lowell.
Edwin A. Clarke, M. D., Worcester.
Amanda C. Bray, M. D., Worcester.
Augustine C. Haub, M. D., Boston.
George W. Butterfield, M. D., Ashland.
Frank A. Hodgdon, M. D., Malden.
Carroll Colby Burpee, M. D., Malden.

Drs. Lougee and Worcester having been appointed to serve as tellers, the polls were declared open for the election of officers.

REPORT OF COMMITTEE ON OBSTETRICS.

MARY E. MOSHER, M. D., *Chairman.*

Dr. Mosher presented an instructive paper, entitled "Minor Aids to Delivery." In an experience with over four hundred cases the author had not found it necessary to use forceps except in two cases.

She believed that very much could be done by the accoucheur to mitigate the sufferings incident to parturition and to assist nature in bringing about a speedy and safe delivery. Among the minor aids to delivery were mentioned hot enemata and douches, hot compresses over perineum and to back, a four per cent. solution of cocaine painted on the cervix for the purpose of relieving pain and facilitating dilatation. The paper closed with a condemnation of the early and indiscriminate use of forceps, which should be used to save life instead of time, and an earnest plea in behalf of conservative midwifery.

DISCUSSION.

Dr. Shaw, of Plymouth, stated that his experience had led to the rather more frequent use of forceps in recent years than formerly, but he heartily condemned the indiscreet use of instruments. There were undoubtedly cases where the careful use of forceps, saved much suffering, and in primaparæ the perineum is not more liable to rupture than when delivery is left to nature. Felt that the greatest danger lay in using too much force. The forceps should rather be used to assist expulsive efforts than to forcibly drag the child into the world.

Dr. Earl did not wish to be understood as countenancing the rash use of obstetrical instruments, but felt that we should discriminate carefully between conservatism and timidity. We should not lose sight of the dangers which may result from delay in the use of forceps. Instrumental delivery does not necessarily mean injury to tissues, and even if a laceration does occur it should be regarded as a comparatively trivial accident, unworthy the attention usually paid to it. Did not consider rupture of the perineum nearly so harmful as overstretching it and depriving it of all its life and elasticity.

Dr. Church, on the subject of afterpains, did not consider them invariably the result of clot in the uterus. Said we certainly had many cases of afterpains where there were no clots.

Dr. Gardner had found the use of the Mercier Belt of great service in those cases where there was lack of tone of the abdominal walls.

Dr. Elliott spoke of the dangers from not using forceps, and mentioned vesico-vaginal fistula as one of the results of unduly prolonged labor.

Dr. Earl, in reply to question, spoke in the highest terms of the axis traction forceps.

REPORT OF COMMITTEE ON DISEASES OF CHILDREN.

J. H. SHERMAN, M. D., *Chairman.*

I. Capillary Bronchitis and Catarrhal Pneumonia.

W. T. Hopkins, M. D.

In this paper, Dr. Hopkins gave a very thorough review of the etiology, pathology, and symptomatology of these affections.

II. Differential Diagnosis of Capillary Bronchitis and Catarrhal Pneumonia, Herbert C. Clapp, M. D.

The author regarded these diseases as nominally one, with predominant symptoms of pneumonia or bronchitis.

III. Hydrotherapy in the Treatment of Pneumonia in Infancy and Childhood, F. W. Elliott, M. D.

Dr. Elliott said that accepting the theory that pneumonia was due to the propagation of a toxine, any measure calculated to combat such toxine should be of most use in treatment. Hydrotherapy had repeatedly proved itself a most potent agent for this purpose. It was of value because it lowered the temperature, diminished the frequency, and increased the force of the pulse, and favored elimination. It also relieved dyspnœa, acted as a sedative and stimulated the nerve centres. Among the methods of application mentioned were high enemata, the partial cold pack (temperature 50°), and the graduated full wet pack.

IV. A Few Suggestions on the Treatment of Capillary Bronchitis and Catarrhal Pneumonia. J. H. Sherman, M. D.

The author laid great stress upon the importance of prophylaxis, urging the judicious care of children in regard to clothing, exercise, bathing, etc. In the treatment of the disease, recommended highly hydrotherapy. Acon., Bry., Tart. Emet., had proved successful remedies.

DISCUSSION.

Dr. Eaton wished to offer testimony in favor of the purely medicinal treatment of pneumonia.

Dr. H. C. Clapp heartily endorsed Dr. Eaton's views, but also believed in the judicious use of cold water, which would not interfere with homeopathic treatment any more than fresh air. He approved of the cold compress as the best method of applying this therapeutic agent. The cold bath seemed to him to be too heroic. In the use of hydrotherapy should be guided in a measure by the condition of the heart.

There being no further discussion the Bureau was closed, and the time remaining before lunch devoted to " new business."

The Secretary, Dr. Richardson, with explanatory remarks to the effect that owing to the growth of the society, and the changed conditions prevailing in the profession of to-day, it seemed desirable that our By-Laws should be revised, stated that

by vote of the Executive Committee he wished to bring the matter before the society at this time.

The principal changes suggested would perhaps be of By-Law No. XXIII, relating to the causes considered sufficient for the expulsion of members from the society. It had been thought there might be substituted for the present causes numbered four and five the following:

(4) For advertising one's self or allowing one's self to be advertised as possessing remarkable or extraordinary powers or ability.

(5) For any conduct which in the opinion of the majority of the members of this society, or of its Executive Committee, shall be dishonorable or unbecoming.

Dr. H. C. Clapp spoke in favor of the proposed revision, and after brief discussion it was voted that a committee of three should be appointed to consider this and other revision of the By-Laws.

The President appointed the following members to constitute this committee, with directions to report at the next semi-annual meeting:

Edward P. Colby, M. D.; Herbert C. Clapp, M. D.; L. Houghton Kimball, M. D.

On motion of Dr. H. C. Clapp, it was voted that $1,000 of the amount now in the hands of the treasurer be invested, under the direction of the Executive Committee, in some good security, and that the interest therefrom may be used by special vote of the society at a regular meeting, as a prize or prizes to be bestowed on a member or members of the society, for medical essays, or other work done, or for the relief of any member in misfortune, or for any other object which the society may from time to time designate.

Dr. N. Emmons Paine offered the following resolution:

Whereas, Dr. Herbert C. Clapp has served as treasurer of the Massachusetts Homeopathic Medical Society for twenty consecutive years, and is now about to retire from his office at his own request, it is therefore

Resolved, That we, the members of the Massachusetts Homeopathic Medical Society, testify hereby to our gratitude to Dr. Herbert C. Clapp for his unvarying courtesy, his faithfulness in the discharge of his duties, and his readiness to give his time and strength in advancing the interests of this society.

This resolution was unanimously adopted with loud applause, and a committee appointed to secure for Dr. Clapp some tangible expression of appreciation.

On motion of Dr. F. W. Elliott it was voted that the publication of the annual volume of Transactions of this society shall be resumed on and after the annual meeting in 1898.

It was also voted that an annual roster of members, containing names, addresses, and office hours, shall be furnished to members of this society.

Dr. Rand offered in writing the following amendment to the By-Laws:

"The Secretary shall forward to all members of this society in good standing, at least two weeks before the date of the annual meeting, an official ballot containing the nominations of the Executive Committee, or by special nomination papers, for all offices of the society. Such ballot must be received by the Executive Committee or special committee appointed for that purpose, at a place designated by the Secretary, at a date not later than midnight previous to date of said meeting."

The society then adjourned to Hotel Thorndike for lunch. The meeting was again called to order at 2.30 P. M., and the President, Dr. Frederick B. Percy, delivered his "Annual Address," in which he reviewed the work of the year and made many valuable recommendations for the future work of the society.

The tellers then reported the election of the following officers for the ensuing year:

President, Howard P. Bellows, M. D.

Vice-Presidents, George S. Adams, M. D.; N. W. Rand, M. D.

Corresponding Secretary, Frederick P. Batchelder, M. D.

Recording Secretary, Frank C. Richardson, M. D.

Treasurer, Winslow B. French, M. D.

Librarian, J. Wilkinson Clapp, M. D.

Censors, H. C. Clapp, M. D.; E. P. Colby, M. D.; Horace Packard, M. D.; F. B. Percy, M. D.; N. Emmons Paine, M. D.

REPORT OF COMMITTEE ON INSANITY AND NERVOUS DISEASES.

N. EMMONS PAINE, M. D., *Chairman.*

I. Thyroid Feeding in Insanity. Cases Treated, and Results.
George S. Adams, M. D.

This paper recounted the method of using, the effects and recoveries resulting from thyroid feeding in the Westborough Insane Hospital, the author heartily endorsing this thereapeutic agent.

II. A Case of Paranoia in its Early Stages. A. Don Hines, M. D.

Was a careful report of a most interesting case, showing the progress and course of this disease.

III. Paranoia. Edith C. Varney, M. D.

Reviewed the latest thought on the subject.

IV. Food for Nervous Cases. Ellen L. Keith, M. D.

In a paper of much practical value the author gave her views on this important matter, mentioning as of special value in the feeding of nervous patients, raw meat, eggs, milk, cocoa, bread, fat, butter, cream, oils, vegetable broths; in anæmic patients, nitrogenous food.

V. The Mucous Colitis of Neurasthenics. James F. Bothfeld, M. D.

Presented the recent views concerning this interesting condition. No discussion.

REPORT OF THE COMMITTEE ON CLINICAL MEDICINE.

GEO. E. MAY, M. D., *Chairman.*

I. Some Cases of Heart Disease. N. L. Damon, M. D.

Dr. N. L. Damon in his paper reported a case of endocarditis. An attack of acute articular rheumatism occurring two or three years previous, resulting in valvular insufficiency (mitral).

II. A Paper, Chas. Chas. R. Hunt, M. D.

Was upon diptheria, and laid stress upon the fact that the disease should not be considered as purely local, and that treatment should look toward systemic results. The most useful remedies had been found to be arsen., kali bi., merc. cyan., phytol. and bell., sprays of peroxid of hydrogen, one part to three of water, or of alcohol one part to three of water. Diet of fresh milk; pineapple juice had also proved useful.

III. Two Cases of Scurvy; One in an Adult Female, the Other in an Infant. Geo. E. May, M. D.

This disease is comparatively rare in modern times. Infantile scurvy is confined to artificially fed children, while that occurring in the adult is supposed to be wholly due to the exclusion of a vegetable diet. The prognosis is good if the disease is diagnosed early. The treatment should consist of a diet of vegetables and fruit acids. Milk, potatoes, squash, and fresh beef and mutton. No salt meat. Orange juice, egg albumen, milk to infants. Nitric Acid, Fer. Phos. may be of use.

Adjourned at 4.30 P. M.

PROCEEDINGS

OF THE

FIFTY-SEVENTH SEMI-ANNUAL MEETING

OCTOBER 13, 1897.

The fifty-seventh semi-annual meeting of the Massachusetts Homeopathic Medical Society was held at Steinert Hall, Boston, Wednesday, Oct. 13, 1897.

The meeting was called to order at 10 A. M. by the President, Howard P. Bellows, M. D.

The records of the last meeting having been read and approved, the following candidates were elected to membership:

Mary Floyd Cushman, M. D., Westborough.

Charles L Farwell, M. D., Allston.

D. H. Swope, M. D., Brockton.

C. H. Fessenden, M. D., Newton Centre.

A. Don Hines, M. D., Boston.

Elmer H. Copeland, M. D., Northampton.

J. H. McLelland, M. D., was elected to Honorary membership.

Dr. H. L. Chase, as chairman of committee on testimonial for Dr. Clapp asked for further time and additional committee. President appointed Dr. Colby, Dr. Coffin, and Dr. Richardson.

At 1 P. M. lunch was served at Hotel Thorndike.

At 2 P. M. an oration was delivered by J. P. Rand, M. D., on "The Obligations of a Physician."

ORATION.

OBLIGATIONS OF THE PHYSICIAN.

BY JOHN PRENTICE RAND, M. D., WORCESTER, MASS.

LADIES AND GENTLEMEN, — It would seem ungracious in me to present a paper of this kind without some acknowledgment of the honor received. I need not say it is appreciated, and right here I wish to thank the executive committee for the compliment implied in its bestowal.

I will not, however, tax your credulity by attempting to cover up my shortcomings with any hackneyed excuse of "lack of time" and "the few moments snatched from a busy practice." I have had time enough; in fact, the most I have to say has been clearly in mind since I began the practice of medicine, fourteen years ago. Whatever, then, this paper may lack in wit, wisdom, or appropriate remark, please do not attribute to any fictitious outside circumstances, but charge it to me direct.

In casting about for a theme on which to rivet your attention, while I essay to supplant your normal after-dinner lethargy with a true hypnotic sleep, or failing in that to render you at least susceptible to "direct suggestion," my eye rested upon this remark of Emerson's with which he begins a unique discourse: "It is said that the world is in a state of bankruptcy, and that the world owes the world more than it can ever pay."

Now I am not here to affirm or deny the universal insolvency of the race. I presume it is so; and that the meanest individual, if subjected to an impartial examination, would fall short in his accounts. But, be the proposition applicable to the general public or not, it surely must be true of the professions, and especially of the one to which we belong. Yes, the physician is a bankrupt in more ways than one, and the debt of his inheritance he can never wholly expect to repay. That old tramp philosophy, that the world owes every man a living, should be counterphrased into this, "Every man living owes the world."

But my theme is on the obligations of the physician, and I have no time or inclination to speak of anybody else. And first, we must acknowledge that the physician shares the common obligation of good citizenship towards the community in which he lives. As a child he

was taught the rudiments of knowledge at the public expense; as a youth he advanced under the fostering care of academy or college; as a physician he is exempt from the summons of the jury box or the muster to arms in battle. And has he in return for these considerations nothing to bestow? Has he no thought or suggestion to improve the sanitary conditions of our time? With our boundless acres and ready means of transportation, must houses continue to be built with no consideration but economy of space? Must the people, already shut out from God's best bounties, sunshine and air, be compelled in addition to drink the pestiferous germs of disease from unfiltered water supplies? Must schoolhouses continue to stand among the most unhealthful surroundings simply because some influential citizen, with no interest in the children whatever, desires to save money on his tax?

Has the physician no protest against pernicious methods of study? Is it simply for him to follow the educational craft, as sharks do a ship, to pick up the wrecks thrown over by the way? Has he no thought for the public library that healthful, helpful reading be placed within the reach of all? Shall the brothel and the dramshop continue to debauch our youth, and the physician walk around with a padlock on his lips to which some patronizing landlord holds the key? The money-gag is thrust into the mouths of us all, and the physician, alas! too often, is silenced by it.

Though politics, as Whitelaw Reid admirably affirms, were in itself the noblest of professions, in times of excitement the physician must dodge between the opposing parties, like the amorphous bat in Æsop's fabled contest of the birds and animals. He cannot be an active Republican, or he will lose Democratic business. He cannot be an active Democrat, or he will lose Republican business. He cannot be a third party Prohibitionist, or he will starve outright. It is sad to admit that under such circumstances the physician may forget the example of the immortal Warren and act the sycophant rather than the man. But the heroes of independence are not all dead! When President Andrews, of Brown University, the other day, resigned his position rather than degrade his rights as a citizen, he set an example for the timid, time-serving, invertebrate hirelings in every profession to consider.

The physician owes it to the community to be a man, to stand up and vote and let his vote be counted; to become a candidate for office even, for positions where medical training is required. He must be indeed a poor observer who could have practised medicine for a period of years and not know, better than the average citizen, that, in the catechism of health — dirt, dissipation, and death are one. The people must be taught that disease is no accident, but the result of inexorable law, and the physician should be foremost to do it. Of what use is preventive medicine? Of what use is sanitary knowledge, if

the one who has it keeps it all to himself? I grant that as yet the physician is ignorant and many times his choicest verities prove untrue, but the people are looking to him for light, and he indeed must be lacking in philanthropy who would not do his best to supply it.

I come now to an exceedingly delicate topic, but one in which I know you are all more or less interested, and that is the church. What obligations rest upon the physician here? I do not agree with Dr. Holland when he stigmatizes the medical profession as a "great army of little men without piety enough to preach, or brains enough to practice law." From what I know of clergymen and lawyers, I should say that in many instances it requires but a very small amount of piety or brains to do either. I am more inclined to that opposite opinion, that "it is a great deal easier to preach than to practice;" and, so far as legal advice is concerned, "more blessed to give than to receive."

I have nothing but praise for the devout physician who goes to church and attends to his business on the Sabbath day. There is no man in the community who needs divine help and consolation more. But I blush for my profession when physicians, whose breath smells of alcohol and narcotics, who fly in a passion and damn their assistants upon the slightest provocation, accept the sacraments divine and present their children for the rites of baptism.

I shrink from the suppressed smile I see creep over an audience when a new physician rushes into church at mid-service, or is called out by some well-trained domestic. "There are tricks in all trades but ours," but, really, must it not seem strange to the unsuspecting that a physician should be so much more frequently called from the church, than from the banquet table or the ball game?

What does the physician owe the church? The same as any other individual. If he deems the institution a public benefit and a safe channel for the bestowment of worthy charity, he owes it moral and financial support, but to bow the head and assent to dogmas he cannot fully accept, *never!*

I come next to that strange relation around which all codes of ethics centre, and about which there has ever been so much individual dispute, and that is, the obligations of a physician to the profession at large. The sentiment expressed by that noble woman, Dr. Nancy T. Williams, who has contributed most to the Hahnemann Monument, because, she said, she owed all she had in the world to him, might well define the obligations of an individual physician to his profession. What does the average physician know of the doctrine he professes that is not due, directly or indirectly, to somebody else? And yet what has the average physician contributed in return? Ay, more, what could the average physician contribute that would by any possibility liquidate his debt? And yet all over this land are petty practi-

tioners, who, having completed the curriculum of some school, or gained by residence a right to practice, deliberately deny their obligations to the profession, and by some secret medical formula or patent device seek to obtain advantage over every one else.

Can there be any attitude more ungracious than this — to glean and sift, and horde from the accumulated experience of the ages, and then bring nothing in return? Success in greed is worse than failure. Well did the old poet exclaim:

> "That man may last, but never lives,
> Who much receives, but nothing gives,
> Whom none can love, whom none can thank —
> Creation's blot, creation's blank."

The main idea of a medical society is a sort of mutual exchange where each contributes from his best experience and partakes in return from the experience of others. But that is not all. It is only by intelligent co-operation and united effort that we can gain our just recognition as an independent school and our individual rights as medical practitioners.

To me it seems that the ordinary physician, or, for that matter, the one who has accomplished most, when he has done his best is still a debtor to his profession; but when he refuses that and deliberately keeps back part of the price, I cannot understand upon what ground he claims fraternal recognition or support. It is a problem, and a most serious one, what action our societies should take in regard to this matter, for the "commercial spirit," like a dry rot, is tainting them through and through. For one I would like to see the option squarely put: "Choose ye this day whom ye will serve." If the golden calf is to be set up in the temple of Æsculapius, let us sacrifice every fraternal relation upon its altar and all fall down together and worship it.

I wonder how many physicians realize the unparalleled philanthropy exhibited in their code, wherein it denies them the right to obtain a patent upon a medical formula or surgical instrument. Is there any other fraternal organization on the face of the whole earth that would declare it derogatory to the good standing of a member to receive a royalty from a beneficent device? Remember this when the taunts of avarice are hurled against physicians, that whatever may be said of an unworthy example, the profession itself stands on holy ground.

What do I owe the profession? I must not disgrace it. To the sum of medical experience I must add my mite, and be that experience painful or humiliating, I must add it just the same. We cannot all be brilliant, but we may at least be truthful, which is better; and the honest, square report of a real case is worth a hundred fairy tales of recoveries — that never occurred.

But the obligations of the physician are not to the profession only,

but to the individual worker with whom he may come in contact. I know no guide save the Golden Rule that can define our relations here. No code of ethics can take account of the man who damns you with faint praise; who says of the young graduate, "He will know more when he is older; or of the hoary physician, "He was good — in his day;" who, called to a case from which another physician has been dismissed, if the patient recovers says, "You didn't call me any too soon;" and if he dies, "You didn't call me soon enough;" who with like adroitness, when the patient of a rival physician dies, remarks, "I wonder he stood it as long as he did;" and should he recover, "Well, God is good."

And yet in the hurry and scurry of professional life the best and sweetest of characters are sometimes maligned and misunderstood. Why is it that the physician who lives in the next town is such a magnificent fellow, and the one who lives next door is — not? Why is it that we criticise the living and canonize the dead? Is there anything in tradition or history more sadly out of place? When the good die they need no eulogy, and the bad — what eulogy can do them good?

But I must not digress. The physician should do what he can to elevate the profession; and there is no better way than by discouraging unworthy candidates from entering it. Is it money he is after? Let him marry an heiress. Is it an easy position? Go seek it somewhere else. Is it a cheap notoriety? Let him become a candidate for office, or publish a book.

The profession is so divided up into specialties that the genuine general practitioner is almost extinct. The question of obligation, then, is not among general practitioners only, but between him and the specialist, and of specialists between one another.

When a patient is sent me by a fellow physician, I must guard his reputation as sacredly as my own. I may not agree with his opinions, and later on I may not agree with the ones I hold to-day, but I owe him at least the courtesy to say he may be correct, which time will very likely prove to be true.

When called in a doubtful case for consultation we must recollect it is neither wise nor kind to impair the confidence of a patient in his physician. How much the mind helps to tide over the crises of disease nobody can fully know. Keep nothing back from the regular attendant, but remember his opportunities for observation have been better than ours, and that in case of disagreement the chances are that he is in the right, for "the best of physicians sometimes make mistakes," — you all know by experience.

I come now to a relation so sacred that its sanctity is even admitted by the courts, and that is, the obligations of a physician to his patient. The patient trusts his all in our hands — "his life, (mis)fortunes, and his sacred honor." We are his confessor, and we owe to him not only

secrecy, but the very best attention we can bestow. Our obligations to our patient are paramount. I say it, and I say it deliberately, as much as we may desire to help ourselves or our professional friends, our obligations to our patients come first. We must do for them the very best things possible, and at all times, without pauperizing them, put them in a way to obtain the best their circumstances will afford; and not only that, we must be considerate. How much better is it than stealing to make a man believe he is ill for the sake of treating him? Some one has said, "The demand of the highway robber is, 'Your money or your life!' but the quack doctor takes both."

And speaking of quacks reminds us that it is not the itinerant physician alone who should be classed under this head. Webster defines the word as "A boastful pretender to medical skill." I know of no reason why a graduate from Harvard, who knowingly and deliberately lays claim to the impossible, is not as truly a quack as the ignorant advertiser.

That physician who, in the present state of medical knowledge, claims to cure *all cases* of cancer or consumption, or even *all cases* of the most trivial disease, has outstepped the bounds of professional decorum, and deserves to be stigmatized as a pretender and a quack. Has the profession fallen so low that a surgeon will perform an unnecessary operation for the sake of the reputation or the fee? Will the obstetrician apply the forceps in a normal labor to make it an "operative case"? Will the gynæcologist discover "a malposition" where none exists, or the orificialist libel the handiwork of the Creator by finding "pockets" in every case? I might extend this list to cover the whole range of medicine and surgery. How easy for a microscopist to demonstrate to a patient the presence of bacteria or casts! How easy for a diagnostician to find the heart or lungs seriously diseased! How easy for the venereal specialist to pronounce a simple ulcer "specific," requiring uninterrupted medical treatment for a series of years! In short, how easy for us all to forget our principles of honor and rush into the practice of medicine like gold bugs to the Klondike mines!

I could write a whole chapter upon this one phase of medical ethics —the Legalized Quack. There is no one in the community from whom a conscientious practitioner suffers so much. He buys books, but not to read them, and displays instruments he knows not how to use. As a class he infests the air around him with a needless pathophobia, and then quiets his terrorized victims with assurances of cure. In the whole range of professional criminals, excluding, perhaps, the dishonest priest who uses purgatory as a means of extortion, there is none more contemptible than an unscrupulous physician who frightens his patient to rob him of a fee.

I come now to the last division of my theme — the physician's obligations to himself; and in that I include his family, which is, or

should be, of himself the dearest part. How like a very inspiration come the words that Shakespeare puts into the mouth of Polonius:

> "To thine own self be true,
> And it must follow, as the night the day,
> Thou canst not then be false to any man."

We will take it for granted that the physician has already been true to his best instincts in his choice of a vocation; that his heart is in his work, and the practice of his profession a delight. And right here lies a most insidious danger. The physician should be the broadest of men, catholic in spirit, of liberal culture, and, what is grander than all, willing to be taught. If the advantages of literary training have been denied him in youth, they must come later in some form or other, or, however successful he may be in certain directions, he is still a pygmy and a dwarf. The practice of an ultra specialty, or the exclusive study of any subject tends to mental myopia, which, like a narrow tire on a wheel, wears quickly out and hurts the road it goes on.

It is hard to draw the line between the physician's obligations to himself and to his patients. He owes it to himself not to attempt more professional work than he can faithfully perform ; he owes the same to his patients. He owes it to himself to keep in touch with all the real advancements in medicine ; he owes the same to his patients. He owes it to himself to preserve his health and intellectual powers from dissipation and excess ; he owes the same to his patients. What right has the physician, more than anybody else, to work day in and night out for months together without a vacation? Is suicide any the less criminal because the process is indefinitely prolonged?

It is inspiring to think of the late Dr. Lewis Hallock, who continued in the active practice of medicine for seventy years ; and among the notable events at our late Institute there was none so impressive or beautiful as that formal presentation of a gold-headed cane to our own Dr. Chase in commemoration of his completed half-century of membership. You remember Dr. Holmes once wittily remarked, "It is better to be eighty years *young* than forty years *old*." And every physician owes it to himself to prove this.

Learn to take a philosophical view of life. The earth had been rolling for some years before we appeared upon it, and will doubtless continue to roll after we have left. There are other physicians here besides ourselves, and some of them quite competent to treat disease. Do not fret because some old-time patient changes doctors. Every doctor has his day, and most of the families you have left at one time employed somebody else. A patient's gratitude is a paradoxical thing ; of the ten lepers who were healed by miracle, only *one* returned even to give thanks. The world is a heterogeneous mass. We can-

not make people all over, even with the "indicated remedy," and the wisest thing to do is to take them as they are and make the best of it.

I have thus indicated in a cursory way some of the obligations which rest upon the average physician. Ability is but another name for responsibility, and the cause we have espoused implies both. I have purposely made no mention of a physician's charities, for there is no man in the community who, in proportion to his means, contributes so much.

The pulpit may make men happier and better, it may promise a heavenly home beyond the grave, but never, while health and friends remain, will it render the saintliest soul in any hurry to get there.

Lawyers, too, are bound to defend the right;

> "Yet, in the corrupted currents of this world,
> Offence's gilded hand may shove by justice,
> And oft 'tis seen the wicked prize itself buys out the law."

But there is a condition common to all, when the solace of the pulpit nor plea of the bar is the solace that will please most. It is when insidious disease steals a march upon you, when the eyes of Pauguk glare upon you in the darkness, when the bullet of the assassin is lodged in your vitals, when the cry is, "Millions of money for an inch of time," it is then and there that this "great army of little men, without piety and without brains," becomes the source of all your hopes and confidence. The physician! To his trust you commit your most guarded secrets; by his advice you accept the most fearful odds; at his fears you tremble, and exult with joy when he speaks of hope.

The physician's office is sacred. He stands at the Alpha and Omega of life. He watches its fevers of summer and its chills of winter. Where the colored card warns the priest and counsel of danger, his duty calls him to go; where the plague and the pestilence abound,

> "He dares a fate the bravest well might shun,
> Nor finds reward save only Heaven's — 'Well done!'"

REPORT OF THE COMMITTEE ON OPHTHALMOLOGY, OTOLOGY, RHINOLOGY AND LARYNGOLOGY.

GEO. B. RICE, M. D., *Chairman.*

I. Reflex Disturbances from Eye Strain. L. Houghton Kimball, M. D. Discussion: John H. Payne, M. D., Albert W. How, M. D., J. M. Hinson, M. D.

II. Report of Case of Cleft Palate with Hare-Lip; Result of Operation. Cicatricial Constriction of Naso-Pharyngeal Space, the Result of Syphilis. T. M. Strong, M. D. Discussion: Horace Packard, M. D., Winfield Smith, M. D.

III. Syphilis of the Nose; Report of Four Cases. Geo. B. Rice, M. D. Discussion: John L. Coffin, M. D., Joseph Chase, M. D.

REFLEX DISTURBANCES FROM EYE STRAIN.

BY L. HOUGHTON KIMBALL, M. D., OF BOSTON.

This so-called Eye Strain may be divided into two kinds, — the intra-ocular or ciliary, caused by the constant and ineffectual effort of the ciliary muscle to counteract a defective refraction of the eye; and an extra-ocular, caused by an effort of the external muscles of the eye to overcome a lack of coördination or equilibrium in the movements of the two eye-balls. The "raison d'être" of ciliary strain will be better understood when we consider for a moment the difference between an emmetropic or normal eye, and an hypermetropic, myopic or astigmatic one.

Rays of light entering a normal eye from a point some twenty feet or more away — at which point they are essentially parallel — will naturally focus themselves upon the retina with the ciliary muscle relaxed and the lens in a state of rest. Now what happens when such parallel rays of light enter a hypermetropic eye — one in which the antero-posterior diameter of the eye or distance from the front to the back of the eye-ball is too short? Obviously such rays, if left to themselves, would focus at a point *behind* the retina, and we should have a blurred image. Now that marvellously exact power of accommodation comes into play; the ciliary muscle contracts, relaxing the capsule of the lens, which then, by virtue of its own elasticity, becomes more convex, thus giving it greater refractive power, and enabling it to converge the rays at a nearer point. They then fall, as they should, on the retina instead of behind it.

When the object looked at is brought nearer to the eye than twenty feet, the rays are *divergent* as they enter it, and consequently require a greater convexity of the lens to focus them properly. This entails a still greater task on that overworked ciliary muscle. How is that condition of things to be remedied? By placing before the eye a convex lens which has the property of *converging* the rays of light before they enter the eye, so that they fall on the retina without much assistance from the ciliary muscle. In myopia exactly the opposite condition holds. The eye-ball is too long from front to back, and the rays of light are naturally focussed at a point in *front* of the retina. To obviate this a concave lens, which has the property of *diverging* rays of light, is placed before the eye, and in this way the rays are made *divergent* before entering it, and are focussed at a point far enough back to fall upon the retina. In simple myopia then there is very little ciliary strain, as the *convex* lens of the eyes has not the power of overcoming this defect, and does not make the attempt. A concave lens in front of the eye is the only resource.

It is in astigmatism that we have the most frequent cause of eye strain. This is a condition in which the cornea instead of being regularly curved in every direction like a segment of a sphere, shows rather an infinitessimal variation in the degree of curvature of its different meridians. It is curved more like an egg or the bowl of a spoon. The rays of light passing through these different meridians can not be focussed at a *single* point on the retina and so produce a blurred and indistinct image. The ciliary muscle makes a constant but futile attempt to neutralize this optical defect, and thus wastes an enormous amount of nerve energy, causing eye-ache, head-ache and nerve exhaustion.

We may have a simple myopic astigmatism in which the refraction of one meridian of the eye is emmetropic or normal and the opposite meridian myopic. In this case the myopic meridian must be corrected by the proper myopic or concave cylindrical lens. We may have on the other hand one meridian normal and the opposite one hypermetropic in which case a hypermetropic or convex cylindrical lens must be used.

We may also have a compound myopic or compound hypermetropic astigmatism in which case there is a myopia or a hypermetropia in one meridian and a greater degree of the myopia or hypermetropia in the opposite meridian, which is connected by a concave or convex lens combined with the corresponding cylinder. We may have finally a mixed astigmatism in which one meridian is myopic and the opposite meridian hypermetropic.

I will attempt to say but little in regard to the extra-ocular condition, as it is an intricate and somewhat confusing problem and rather beyond the scope of this paper. To obtain distinct and single vision the visual line or axis of each eye should tend to exactly the same

point. This condition obtains when the eye muscles are properly balanced and of equal strength.

When the opposite condition holds and the visual lines diverge from each other to an appreciable extent, we have diplopia or double vision, a separate image being formed on the retina of each eye. Between these two extremes there is an intermediate condition, in which there is single vision to be sure, but it is obtained by an unusual effort on the part of some one of the extra-ocular muscles in its attempt to counteract a *tendency* of the visual lines to diverge.

Orthophoria — from the Greek words meaning a right tending — is the term generally used to designate a normal condition of balance of the eye muscles, a tending of the visual lines to exactly the same point.

Now if there exists a disproportion in the relative strength of the superior and inferior recti muscles, there is a tendency of the visual line of one eye either above or below that of its fellow. This is determined by placing prisms of the proper strength, with the bases in, before the eyes. In accordance with a law of optics, which I will not enter into here, these prisms will cause one eye to diverge laterally from the other to the extent of causing double vision. Now if there is no disparity in the relative strength of the superior and inferior recti muscles of the two eyes, we should see the two images of the candle, which is placed some twenty feet in front of the eyes, on exactly the same horizontal plane. If, however, there is a tendency of the visual line of one eye a little above or below the visual line of the other, we should see the two images *not* on the same horizontal plane, one appearing to be a little higher than the other. The degree of this divergence is measured by the prism which, with its base placed up or down before one of the eyes, will bring the images to the same level again. This disturbance in the vertical equilibrium — if I may use the term — or the tendency of one eye to rise above its fellow, is called hyperphoria. In the same way we may trace a disturbance in the lateral equilibrium, a tendency of the visual lines outward being called exophoria, and a tendency of the visual lines inward called esophoria. This is determined in a similar way by placing a prism with base up or down before one of the eyes. This would occasion one eye to turn a little above its fellow, causing a vertical diplopia. Now if there is a just balance between the external and internal recti muscles, the two images would be seen in exactly the same vertical plane, one being seen just above the other. If esophoria or exophoria existed, one image would swing to the right or left of the other, and the degree of the defect would be measured by the strength of the prism which, with the base in or out, as the case might be, would bring the images back to the same vertical plane. These muscular insufficiencies, especially hyperphoria, even of a slight degree, are the cause of many nerve reflexes, such as headaches, pain in back of head

and neck, nausea, vertigo, and, according to some authors, notably Ranney, chorea and epilepsy.

These defects may be improved and many times corrected by strengthening the weaker muscle through a system of gymnastic exercises by the use of prisms of regularly increasing strength by the wearing of prismatic lenses, or as a last resort by graduated tenotomies in the stronger muscles.

Cases illustrative of the above mentioned conditions have been published so frequently that a recital of many of them would undoubtedly seem to you like the proverbial chestnuts, so I will content myself and let you off easily by pulling only a few of them from the fire.

Case 1. Mr. K., aged twenty-five years, a travelling salesman, had suffered for a long time with intense headache accompanied by billious vomiting. He attributed them always to irregular meals or some indiscretion in eating. I treated him with remedies for some time but with no relief. Suspecting a possible eye-strain I suggested an examination. He was rather amused at the suggestion, insisted that his eye-sight was first-class and that he would not consent to wearing glasses.

His vision was indeed normal, but retinoscopy — a method of estimating the refraction by the ophthalmoscope — revealed a very slight myopic astigmatism, and a minus 25° axis 180°, which he finally consented to try, gave him such complete relief that he has worn them constantly ever since without a murmur.

Case 2. Mr. ——, of Brookline, came to me in Aug., 1896, at the suggestion of his physician. When a child he had had three tenotomies made for a strabismus. He had been fitted to glasses for near vision, but was still suffering greatly with dizziness and even diplopia at times, to such an extent as to prevent him from attending to business.

It had *not*, however, prevented his becoming engaged to a young lady in New Hampshire a short time previous to my seeing him.

His distant vision was also normal, but retinoscopy showed an hypermetropia and a spasm of the accommodation. I suggested an examination under atropine at which he at first demurred when I told him he could not see to read or write for a week or so. Probably he did not enjoy the prospect of writing to his intended by proxy or having some disinterested third party reading her letter to him. When I suggested, however, that he could go up and spend a week at her home while the effect of the atropine was passing off, and that it would be a good excuse for him to sit in a darkened room, he immediately consented. The examination under atropine, relaxing the ciliary spasm, showed not only a hypermetropia, but some hypermetropic astigmatism, and a glass of $+2° = +75°$ axis 45, right eye, and $+1° = +50°$ axis 12°, left eye, gave him complete relief and enabled him to resume his business.

Case 3. Mr. B ——, a Williams College student, came to me at the suggestion of Dr. May, of Newton Centre.

He had been having serious trouble with his eyes and head, had tried many glasses from different sources, had been obliged to leave his college work and was discouraged.

He could do no studying, his brain feeling sore and bruised, his eyes aching and so sensitive to light as to necessitate smoked glasses. His convergence was very weak, but under exercise with prisms increased from 14° to 47°. Under atropine a hypermetropic astigmatism was manifest, and a cylinder of 1.75 axis 100, right eye, and 75° axis 90, left eye, was prescribed.

He returned some weeks after, having discarded his dark glasses, regained his courage, and happy in his return to college work.

Case 4. Mrs. P ——, of West Roxbury, came to me in October, 1890. Said she could not remember when she had not had headache and eyes-ache.

Could not go out anywhere in evening to an entertainment without suffering severely for it. Her vision was normal and even under atropine could only find the slightest possible degree of astigmatism in right eye. There was, however, weak convergence and the internal recti muscles were strengthened by prismatic exercises.

She showed also an esophoria — a tendency of the visual line inward — to the extent of 2°. For this a prism, with base out, gave her great relief for awhile. During its use, however, more latent esophoria showed itself to the extent of 5°, so that in March, some six months from the time she first came to me, I made a partial tenotomy of the internal rectus of the right eye, correcting the esophoria and restoring the muscular balance. I quote the following from her report three weeks afterward: "No drawing in either eye, no headache; feel splendidly." I saw her last December. She had in the meantime been able to use her eyes to the average extent, and showed but $\frac{3}{4}$° of esophoria.

1. HARE-LIP AND CLEFT PALATE, WITH REPAIR OF FORMER. 2. CICATRICIAL ADHESION OF PALATE.

BY T. M. STRONG, M. D.

On April 20th of the present year my attention was called to M. S., a lad of 15 years, a well-preserved, healthy looking boy. Examination showed complete cleft of hard palate, with absence of soft palate, and marked hare-lip deformity. The turbinated tissues were bluish in color and very much enlarged, giving in fact a compensatory roof to the mouth. The faucial tonsils were also very much hypertrophied. The disfigurement was aggravated by the prominence of the two canine teeth. When four months old an operation to repair the hare-lip had been attempted, but it was a failure, and nothing further had been done to relieve the repulsive deformity.

At a recent meeting of the Laryngological Society of London, two cases were presented with apparently very similar physical characteristics as the above. The discussion turned on what to do with these enlarged turbinated tissues. The concensus of opinion was rather towards conservatism, leaving them either alone or removing but a portion. It was stated that in many of these cases there was complete arrest of development, not simply a want of union, and these tissues served a useful purpose in providing a roof for the mouth. Again, there was no normal function to be restored in these cases, perfect articulation never having been acquired. This the patient should understand, for otherwise his disappointment at the failure to restore this function may be extreme, and the operation was oftentimes sought to obtain this result only.

In the present case we removed the tonsils, and at different times small portions of the inferior and middle turbinateds, anteriorly and posteriorly, with the snare and cautery, giving considerable breathing space. Each day the throat and adjacent parts were thoroughly cleansed with antiseptic washes.

On June 27 we attempted the operation to close the lip and alveolar space. An incision was made on the end of each maxilla down through the periosteum, the two teeth having been previously extracted, the tissues thus loosened were brought together in the median line forming a bridge across the space, silk sutures being used to retain the parts. The edges of each cleft of lip was then incised, the tissues thoroughly loosened and advanced, and held together with continuous catgut sutures through the mucous membrane and skin. Three silkworm retaining sutures were used, and the parts covered with cotton

and collodion dressing. Nothing was attempted with the cleft palate, the intention being to refer him to a mechanical dentist to fit an obturator. Dr. W. J. Winn kindly assisted and to his skill in general surgical technique much of the successful result is due.

Case 2. F. H. says that up to his thirteenth year he was considered as more robust than the average boy of his age. At this period he began to suffer with malaise and headaches, and was unable to attend school with any regularity. During the winter he fell on the ice and hurt his knee which became swollen, requiring attention for several months, during a portion of this time being confined to the bed, taking cod-liver oil for some time, with extension apparatus on the limb. For a few weeks he had an inflammation of the eyes, its exact character not determined. In the fall of '93 he took up his school duties again, and was in fairly good health, the knee giving no further trouble. In January, '94, a new onset of inflammation appeared in the eyes, which was treated by Dr. J. H. Payne, and from which he had fully recovered by the following summer except that the eyes are not quite as strong as before. In June, '94, his throat began to trouble him, seemingly an attack of catarrhal pharyngitis, which improved under treatment, but in the following winter, coincident with a severe cold, it returned with renewed vigor, assuming a pseudo-membranous form, with later ulceration and destruction of the uvula, and the adhesions, the subject of the present paper, were probably then formed.

He was admitted to the hospital in February '96, then nearly seventeen years of age. On examination there was found extensive palatal adhesions, so that the only breathing space was through an opening about one quarter of an inch in diameter. There was no remnant of the uvula. There was a profuse discharge of a muco-purulent character, containing broken down epithelial debris, with round celled infiltration of the submucosa.

While in the hospital he was under the care of Dr. W. S. Smith, who prescribed an anti-specific treatment, while the local treatment was carried out by the writer, which consisted of hydrogen dioxide and antisepo. Later under ether the adhesions were severed with the knife and their reunion opposed by dilatation, but to no purpose, for the opening was soon as small as before. Still later I used the actual cautery but the result was the same. We may say that soon after his admission to the hospital the discharge began to improve and soon disappeared leaving the mucous membrane in apparently healthy condition.

In looking over some copies of the *New York Medical Journal* I found the following description for the relief of these conditions as described by its author, Dr. J. E. Nichols, of New York City: "In the case of acquired or congenital webbed fingers or toes we had an analogous condition, . . . and success in their treatment depended

upon the establishment of a healthy cicatricial surface of greater or less extent, which must be obtained at the bottom of the web near the junction of the fingers, before separation of the rest of the web was made. There being a healthy cicatrix at the bottom, the separated parts had no means of coming together by adhesions starting from that point, and consequently healed with a line of cicatricial tissue on either finger, but no connecting web. The first step in the present operation was to thoroughly cocainize the throat. If there was complete closure, the thickness of the adhesion was ascertained by passing a steel curved bougie through the nostril into the naso-pharynx and palpating the end of it by means of the index finger in the oro-pharynx. When this was done an opening was made by a bistoury, and the operation continued as if the opening had been partial. An ordinary staphylorraphy needle, curved to the right or left as required, was now armed with four to eight strands of coarse black silk suture. It was then passed through the central opening into the naso-pharynx and carried as far as possible directly outward away from the median line. Then by a turn of the handle it was brought into the oro-pharynx. The tissue being very tough it was neceesary to afford a point of resistance by a long forceps against the palate anteriorly. One end of the suture was then grasped by a forceps and drawn out, and the ends tied in a surgeon's knot near the central opening, leaving the loop loose enough to play freely through both perforations. If the adhesion was bilaterial, the same process was repeated on the other side. The loop is then drawn upon until the knot lies in the naso-pharynx. Each day the suture is moved slightly back and forth, and at the end of ten to fourteen days healing has taken place, and there remains a small canal of cicatricial tissue slightly larger than the diameter of the suture, through which the latter works freely. Traction is now made on the loop towards the median line, in order to stretch the canal, and into it is introduced very carefully a narrow, blunt pointed knife curved on the flat. The tissues are then carefully cut through, and the parts kept dilated with the finger or dilator until they heal."

On April 30th of the present year the patient was again admitted to the hospital, and assisted by Drs. Parmenter and Whittier, of the House Staff, we made the attempt to operate on the lines here laid down. As the author had intimated the chief difficulty lay in introducing the sutures, but after some difficulty both were finally in place and the patient returned to the ward. The mouth was carefully cleansed each day but in spite of all our efforts the old discharge of the previous record returned to plague us, and the perforations refused to cicatrize. Worse than this, the right ligature sloughed out, and the tissue adhered as before. The left more slowly, but as surely, followed, and to-day the old opening is all that remains as the result of careful treatment on the part of my predecessors, and conscientious,

if not skilful, treatment on my part. In a personal letter from the author he says he has had but one unsuccessful case. The above description was written several years ago, but the later technique of the operation is given in the report of the proceedings of the American Laryngological Association for 1896, together with a description of the instruments especially adapted for the operation. The operation was highly commended in the discussions which followed the presentation of both reports by Dr. Nichols, and with the experience already gained and the proper instruments, I should not hesitate to advise the operation in the case of another patient suffering from palatal adhesions, with the hope that it would not present the same destructive ulcerating tendency, and might demonstrate a little more skill on the part of the operator.

SYPHILIS OF THE NOSE, WITH REPORT OF FOUR CASES.

BY GEORGE B. RICE, M. D., BOSTON, MASS.

The tertiary form of syphilis is of great practical interest to the physician, from the fact of its comparative frequency, of the great difficulty oftentimes of obtaining any history of the primary lesion, and of the years which may elapse between this lesion and the local tertiary manifestations.

The initial lesion rarely occurs in the nose, though the disease may be communicated in a variety of ways other than by cohabitation. Many cases of chancre of the lip and tonsils have been reported.

Perhaps some of you will remember of a case reported by myself before this society, some years ago, where the disease was communicated to an abrasion of the lip. Secondary lesions do not often show themselves in the nasal passages in adults, though in children suffering from congenital syphilis, coryza, and nasal inflammation, probably manifestations of the secondary stage accompanied by the typical skin eruption are frequently found. But, with one exception, I have not succeeded in finding any record of chancre occurring in the adult nose.

This exception was a case reported by Dr. John L. Coffin in the *New England Medical Gazette*, November, 1896. The third stage, on the contrary, is often here localized. As is the case with tertiary lesions elsewhere, periods of from three to fifteen years or more may elapse between the original infection and the pathological process under consideration. The early symptoms may have been so slight

as to have escaped notice, the secondary process lacking in many of the characteristic symptoms, and therefore undiagnosed, so that if from the local condition of the nose you suspect syphilis, the patient however honest, may be totally unable to give you any facts in the history of the disease which could possibly be of service.

When we add to this early uncertainty a desire on the patient's part often to conceal the nature of the disease, it is then no wonder that the diagnosis sometimes becomes difficult.

The cartilaginous portion of the septum, as a rule, only on one side, is the most common portion of the nose affected by the gummatous infiltration. Isolated gummatous tumors, though occurring, are more rarely seen ; the appearance is, rather, that of a general submucous infiltration, involving the whole anterior portion of the nasal septum. The disease, apparently, in a measure, respects anatomical boundaries, as is seen in the fact above stated, that the infiltration is often confined to the cartilaginous portion of the septum. This same infiltration may affect the perichondrium and cartilaginous tissue as well as the softer parts. Next in frequency are infiltrations of the inferior turbinated body. Here also the infiltration involves not only the softer parts, but the periosteum and bony substance itself. Often these tissues, the ethmoid, vomer, and floor of the nose, are involved. The infiltration, following the same general rule, rarely invades the naso-pharyngeal space if the intra-nasal tissues are primarily affected; nor does it extend to the vestibule and outer portion of the nose, although the nasal bones may be diseased with external puffiness, and redness over these bones, as evidence of the internal diseased condition. From these facts it is readily seen that the symptom from which the patient first complains is unilateral nasal obstruction. If the gummatous deposit is considerable, the obstruction will be accompanied by a heavy boring pain in the nose, this symptom lasting sometimes for many months before the breaking-down or ulcerative process begins. This ulcerative process involves only those portions invaded by the gummatous infiltration.

If the destructive process be not arrested, the destruction of the nasal tissues may be so considerable as to produce marked external deformity. The symptoms of the second stage then must be of a different character, namely a certain amount of freedom from the nasal obstruction, a considerable discharge of muco-purulent material mixed with shreds of necrosed tissue and accompanied by a most disagreeable odor. Especially is this latter symptom manifest if the nose becomes occluded by this cast-off material. The general health of the patient now suffers. Headaches, a sense of lassitude, poor appetite, poor digestion, and loss of weight, accompanied by a certain amount of nervous irritability, occur. Only three other diseases of the nose present symptoms which are in any way similar : chronic rhinitis (only similar in the first stage of the tertiary lesion), sarcoma, and

tuberculosis. If the diagnosis is not clear, the administration of some form of iodine will, in the majority of instances, eliminate or substantiate the presence of syphilis. Regarding the treatment of the disease, there is, I believe, quite a difference of opinion in our school as to whether or not we are justified in giving material doses of the iod. of pot. or iod. of sod., followed by, or combined with, some form of mercury. Our "Homeopathic Materia Medicas" have in them drugs presenting symptoms similar to the syphilitic nasal diseases under consideration, notably am. met., kali bich., hyd., phy., and iod., but I believe we have insufficient evidence of cures performed by these drugs, or of the deposit of gummatous material, followed by this destructive process, having been controlled by small doses of the indicated drug.

I have known of a number of cases, under the best homeopathic medication, to have gone from infiltration to destruction of healthy tissue without apparent interruption in the slightest degree. For many years it has been a well-known fact that iod., in the form of pot. or the iod. of sod., has a very marked and immediate influence upon the development of the gummatous tumor.

It seems homeopathic to the disease, but is not sufficiently so to enable us to arrest it with small doses of the drug; ten, twenty, thirty, and even sixty grains of the iod. of pot. daily are frequently necessary to arrest the progress of the disease.

To the earlier stages of syphilis, and to the stage following the gummatous deposit, merc. seems homeopathic, but here again it must be used in material doses in order to produce the desired effect.

I trust that if any here present have had experience with the treatment of syphilis with the homeopathically indicated remedy, that we may be given the benefit of such experience, for it seems to me that as we stand at present the treatment of syphilis, by strictly homeopathic medication, is far from satisfactory. The cases I have to report are as follows: —

Case 1. Mrs. A., age fifty-three, consulted me November 3, 1896. Complained of nasal obstruction on right side. Since August had slight pain, watery discharge from this side; general health poor. Absolutely no history obtainable.

Examination showed infiltration of the inferior turbinated body, almost completely obstructing nasal respiration, on this side. It was with difficulty that the probe could be introduced into the nose between the turbinated body and septum.

The reduction of the infiltrated tissues with cocaine was very slight, but sufficient to show an ulcer involving the upper middle portion of the turbinated body, of hard base and raised edges, filled with grayish semi-cheesy material, giving rise to considerable odor. The other portions of the nose and throat seemed to be in normal condition, except for slight redness of the soft palate. Suspecting syphilis, I

gave the patient three-grain doses of the iod. of pot., combined with essence of pepsin, after each meal, while I cleansed the ulcerated surface thoroughly with peroxide of hydrogen, sol. November 27, no change. I increased iod. to five grains after each meal.

December 1, very much better. Continued medicine. From that time until the day of her discharge (February 5) there was steady improvement, so that on this date respiration was quite free on the affected side, and the ulcer had disappeared.

The patient was directed to consult the family physician, and be treated constitutionally for some months. In this case the lesion was slight and the discomfort not very great, but it was undoubtedly a mild manifestation of the tertiary form of syphilis.

Case 2. Mr. M., age forty-two, consulted me June 14, 1897. Gave history of nasal obstruction of both sides since last October; greatly increasing, so that for the last four mouths has not been able to breathe through the nose at all. Complains of soreness of right nostril and of occasional bloody discharge from the nostril. General health not very good. Complains of nervous irritability and fits of depression. On examination the soft parts of both sides were so infiltrated as to render inspection of the internal portions of the nose impossible. Upon reducing the parts with cocaine a long ragged ulcer was found on the cartilaginous septum on the right side, which at one point had almost produced perforation, surrounded by redness and infiltration. I was unable to obtain any history substantiating the evidence of syphilis, but notwithstanding this fact, after cleansing the parts thoroughly, prescribed five-grain doses of the iod. of pot. after each meal for three days, then to increase the third dose to ten grains. June 29, the infiltration almost entirely disappeared. Could breathe through nose perfectly. Ulcerative process over cartilage lessened. Kali. iod., ten grains, after each meal and before going to bed.

A month later his physician telephoned me that the nose seemed to be in a perfectly normal condition. Advised continuation of iod., followed by merc. bin., for some time.

Case 3. Mrs. L. consulted me April 28, 1897. Complained of pain and stiffness of the nose, of profuse watery discharge (sometimes purulent). Difficulty in breathing, dating from October last.

Examination showed apparent atrophy of the inferior turbinated body on the right side, of general infiltration of the soft part, deflection of the cartilaginous septum toward the left, and hypertrophy of the left inferior turbinated. Directed her to cleanse nose twice daily with an alkaline solution, followed by an application of melted vaseline in an atomizer. Prescribed protoiode of mercury 3 x tablet every two hours.

May 1, about the same. Left side slightly better. Treatment continued.

May 3, only slightly, if any better. Treatment still continued.

May 5, rather better.

May 10, nose looks very badly. Slight puffiness and redness over right nasal bone. Suspect syphilis, but can obtain no history, and the appearance and social position of the patient would rather exclude the disease in one's mind. I did discover, however, that husband was suffering from locomotor ataxia. Knowing this disease to be frequently of syphilitic origin, I gave patient three-grain doses of iod. of pot.

May 17, found nose in very much better condition. By persistent questioning I discovered that ten years previously she had suffered from an ulcerative sore throat, lasting for some months. Increased iod. to five-grain doses four times daily.

May 22, head cold. Discontinued potass. iod. and substituted merc. prot. 2 x every two hours.

June 1, about the same. Prescribed mercu-auro, three drops morning and night, with three grains of iod. of pot. after each meal.

June 7, increased mercu-auro to five drops, iod. of potass. the same.

July 6, nose very much better. Can breathe comfortably through both sides. I then discovered that the ethmoidal septum had been perforated. The supposed atrophy of the inferior turbinated body was really a breaking down of the whole structure through a former gummatous deposit. There was no ulceration in the left side, but the right side had undergone very extensive syphilitic infiltration. As merc. aur. seemed to interfere with the digestion, I discontinued it and gave nux. vom. for three days and then returned to iod. of pot. after each meal. Patient has steadily improved up to the present time in every way, although there is still considerable discharge of muco-pus from the nose.

Case 4. Mr. T., age fifty, consulted me October 9, 1896, suffering from obstruction of the right nostril, with excoriation of the lower anterior portion of the right side of the cartilaginous septum.

The obstruction had been of over a year's duration. Little or no discharge from this nostril, but there was a sense of fulness and dryness. General condition not good. Subject to fits of melancholy and of nervous irritability. Emotions easily aroused. Thinking the condition to be a simple rhinitis, and the ulceration of the cartilaginous septum to be a mechanical irritation by the patient's own finger nail, I prescribed an alkaline douche for the nose, and owing to some general symptoms gave internally kali bich.

October 16, slight cold. Otherwise condition the same.

November 7, no better. Owing to a peculiar condition of the tongue, I questioned patient and found probable evidence of an early syphilitic lesion twenty years ago. Prescribed iod. of pot., six grains after each meal. To continue alkaline douche.

November 23, nose very much better. Continued.

November 24, very little trouble in the nose. Ulceration on cartilaginous septum healed. Directed patient to continue medicine. He did not come in again until April 21, nearly three months later. Had taken no medicine for a month, and as a consequence nose had been troublesome again. Prescribed merc. bin. 2 x tablet every two hours. April 28, no medicine for a week. Nose about the same. Complains of pain in lower portion of the chest, with troublesome cough. General symptoms better, bry. 3 x four times a day.

June 2, feels generally better, but nose is stopped up again and is almost as uncomfortable as at first. Prescribed iod. of pot. five grains, after each meal for three days, then four times a day.

June 30, nose unobstructed and comparatively free from any abnormal appearance.

July 27, no trouble with nose. Has continued medicine. From the fact that the symptoms subsided under the iod. of pot., to reappear from its discontinuance and from the early history obtained, rather late in the treatment of the case, I felt fairly sure it was a case of tertiary syphilis of the nose. From these cases and a few others I have been fortunate enough to see I cannot draw accurate deductions, but from the facts obtained in watching the disease, besides observations on quite a number of cases where the disease was locally manifested on the soft palate, pharynx, tonsils, hard palate, and larynx, I have come to place considerable reliance on the iod. of pot., as an aid in diagnosis, and as a powerful agent toward preventing destructive processes.

DISCUSSION.

Dr. Payne:—A perusal of Dr. Kimball's paper has suggested several "thoughts" to me, that I have put in writing, regarding disturbance arising from eye strain. Much has already been written upon this subject, but not overmuch, if it will but result in drawing the intelligent attention of the profession to this source of evil. Not alone the great ills of life should demand our attention, but also the petty ones, annoyances, insidious advances of a silent enemy that will eventually overpower the citadel of our health. Such are distressing headaches coming at a most inopportune time to upset all our prearranged plans; a tired, exhausted feeling on the least exertion ultimating in complete nervous prostration; insomnia; melancholia; and kindred troubles. These, and many more are consequence of prolonged eye strain, and they can only be remedied by correction of the eye defects. Their insidious character is evidenced by the fact that frequently *no local manifestation of eye trouble is apparent, no perceptible fatigue of the eyesight during the progress of the strain*, but merely a sense of general exhaustion after a few hours of shopping or of riding in the cars, a lowness of spirits, a diminution of appetite and a loss of interest in

present affairs that signify a lowered vitality, and a condition that renders one very open to the influence of disease. Frequently a correction of eye defects will turn the scales in favor of the patient when combating a delicately balanced disease that threatens to overpower by its weight. Consider for a moment the delicate mechanism of the eye sight and the unceasing demands upon it for fifteen hours out of every twenty-four; the thousands of readjustments that the muscles, moved by impulse from the nerve centres, are compelled to make in following the shifting panorama of our daily life, readjustments that must be swift and accurate in order to focus objects clearly and that, often times in spite of integral defects in the machinery of motion that compel an increased amount of nerve force to execute these manœuvres. This constant over demand upon the nerve supply can result in but one thing, viz., nervous exhaustion and its attendant ills. I have known profound melancholia with suicidal impulse to arise from eye strain, and this in a case in which the vision appeared to be perfectly correct, and in which attention was called to its nature only by mere accident. No pronounced fatigue was felt in the eyes themselves, but a sense of lassitude as the day progressed, and a decided depression of spirits that was overpowering. An examination revealed perfect vision for each eye separately, but a want of balance in the relative adjustment of one eye to the other, a weakness of the recti muscles, that had sapped the source of nerve supply to such an extent as to render it unfit for its daily work. This patient would not believe at first that it could be the eyes that were at fault, because, as he said, "I can see perfectly well from both far and near, and my vision is not clouded in the least." That reasoning would have held well with oculists ten years ago, but now they know better, because they have found that no vision is good and in healthy running order and free from menace to the general health until the balance of the eyes in their relation to each other is perfect to the smallest fraction of a centimeter. This case was completely cured by attention directed to the restoration of this disturbed balance, and his melancholia has entirely disappeared.

Such a case is of great significance to the careful observer, and in addition, satisfies his intelligent research for a fundamental cause for such a profound disturbance. Insomnia is another result of eye strain, and is often caused by derangement of the function of both the ciliary and the recti muscles, alone, or in conjugate action.

Dr. Payne also spoke of action of scopolomine in glaucoma as being more transient than that of atropine. Believes that former drug may cause glaucoma.

Dr. Packard in discussing hare-lip, urged early operations.

Dr. Coffin in discussing Dr. Rice's paper. No part of the economy where syphilis so often sets its official seal. Necessity of early diag-

nosis of these troubles. Believes in diagnostic value of kali, iod. If non-syphilitic we soon get iodism, if syphilitic we soon get improvement in the case. Malignant growths would not improve under iod. treatment. Tuberculosis and lupus, prefer cartilage, syphilis bone, is an old adage, and this holds good to a certain extent. The perforations of syphilis especially apt to occur at junction of cartilage and bone. As regards treatment, majority need one treatment, and that the internal administration of kal. iod. which must be given in material doses. Triple iod. of gold, ars. and merc. is not satisfactory. Chloride gold and soda after long iod. treatment is good substitute.

REPORT OF COMMITTEE ON SURGERY.

WINFIELD SMITH, M. D., *Chairman.*

I. Cases of Sprained Ankle Treated by the Gibney Method. F. P. Batchelder, M. D. Discussion: Carroll C. Burpee, M. D.
II. Report of a Case; Tuberculosis of the Intestine, Excision, Anastomosis, Recovery. F. W. Halsey, M. D. Discussion: J. W. Hayward, M. D.
III. Appendicitis. N. W. Emerson, M.D. Discussion: W. J. Winn, M.D.
IV. The Surgical Treatment of Diphtheria, with Report of Cases. J. Emmons Briggs, M. D. Discussion: George E. May, M. D.
V. Enlargement of the Prostrate. Horace Packard, M.D. Discussion: A. Howard Powers, M. D.

CASES OF SPRAINED ANKLE TREATED BY THE GIBNEY METHOD.

BY FREDERICK P. BATCHELDER, M. D., BOSTON, MASS.

The growing tendency in the treatment of several surgical conditions is for the adoption of some method whereby the patient can be kept about on his feet, and even continue at his customary vocation.

Any method which can thus assist in effecting a successful result, with but little or no loss of time or wages, at once commends itself to our attention.

The experience of many members of the medical profession has not been encouraging, so far as the treatment of a sprained ankle with rest, fomentations, etc., is concerned. Massage has often proved of much assistance in affecting a cure.

The writer's attention was directed in 1895 to an article by V. P. Gibney, M. D., Surgeon in Chief to the hospital for the Ruptured and Crippled, which appeared in the *New York Medical Journal* of February 16, 1895, entitled "Sprained Ankle; a treatment that Involves no Loss of Time, requires no Crutches, and is not attended by any Ultimate Impairment of Function."

The method as described by Dr. Gibney, was, so far as known, first employed by Mr. Edward Cotterell, of London. It consists in the application of ordinary surgeons' adhesive plaster, in strips of suitable dimensions, to the injured foot.

The most frequent focus of injury and swelling is in front of the external malleolus, at the site of the external calcaneo-astragaloid ligament and the anterior fasciculus of the external lateral ligament.

MODE OF APPLYING THE STRAPS.— Usually strips three-fourths to seven-eighths of an inch wide and twelve inches long will be suitable for applying, and fit the varying convexities and concavities of the surface much better than wider ones.

The first strip is applied along the lower margin of the outer border of the foot, commencing near the little toe, and carried around the heel along the inner margin of the foot to about its middle, and just beneath the plantar arch. Strip No. 2 is applied vertically, commencing at the junction of lower and middle thirds of leg, and carried downward alongside the tendo achillis, beneath the heel and up to a point just above and behind the internal malleolus. Strip No. 3 is applied horizontally, parallel with No. 1, and overlapping it about one half. No. 4 is applied vertically in the same relation to No. 2, and subsequent strips are applied alternately horizontally and vertically in numerical order, until the whole outer aspect of the foot is covered in. Several horizontal strips are then applied in succession up to the top of the vertical strips to reinforce these and keep them in place.

On the inner aspect of the foot no such methodical order can be followed, for the terminal ends of the strips must be allowed to go in that direction which will permit them to fit the surface and adhere well.

A space at least one half inch wide should be left uncovered up the front of the foot and leg. Thus the strapping does not at any point entirely surround the foot, and hence cannot constrict it.

It will usually be found desirable to carry a reinforcing strap obliquely downward and backward, just in front of the external malleolus, around or beneath the point of the heel and up on the inner surface several inches. Thus the injured ligaments and tissues before mentioned receive additional care.

Over all a gauze roller bandage should be applied and worn for a day or two, until the strapping has become thoroughly adherent and moulded to the contour of the foot. A stocking and shoe can usually be put on at once, and the patient urged so use the foot somewhat.

In most cases it will be desirable to restrap the foot at the end of ten to fourteen days, the new straps to be worn a similar length of time. Only rarely will a third strapping be required, and that in chronic or neglected cases.

The method commends itself —

First. Because of its simplicity and ease of application, a pair of scissors and a spool or roll of adhesive plaster being all the apparatus required.

Second. It does not constrict the foot at any point, and hence cannot increase the swelling.

Third. It affords support to the injured tissues and still allows patient to be on his feet without detriment, the foot executing adequate flexion for walking without difficulty.

The following cases are selected from those I have treated and illustrate well the average results:

Mr. G——, commercial traveler, consulted me at my office in July, 1895, for some medical disease and incidentally referred to his sprained ankle, injured six or more weeks previous, saying that he did not suppose I could do anything for it, as he had been under treatment at —— Hospital all the time, and they finally told him he would have to let nature and time effect a cure. He limped a good deal and had to use a cane. The following day I, for the first time, applied the strapping to his foot, but not without some uncertainty, for although Dr. Gibney's results seemed marvelous, yet such a chronic case did not promise well. The patient experienced great comfort at once, and came to the office two days later for inspection. He had no use for a cane, limped very much less, and could walk with comparative comfort.

In a few days more he resumed his former occupation, which necessitated a great deal of stair climbing, and had no further trouble. The ankle was restrapped twice, and the result was all that could be desired.

Mr. R——, one of the advertising agents for Quaker Oats, on returning to his boarding place one Saturday evening, sustained a severely sprained ankle when alighting from a horse car in motion, and carrying a heavy valise in one hand. A similar accident years before had kept him confined to the house six weeks.

I saw him shortly after the accident, and the ankle was swelling rapidly. He could hardly use the foot. This was at once elevated, with patient lying down, and cool compresses were applied and frequently changed. In two hours the swelling had ceased to increase, and the strapping was applied, with good reinforcement over the point of injury, just anterior and below external malleolus. He was at once able to stand on the foot with but little discomfort.

The next morning he walked about without a cane, and after being cautioned to use a cane that day when going out, walked down two flights of stairs, took a car to the Union Station and a train to Lexington, returning the latter part of the afternoon. The next day, Monday, he went to Lowell and resumed his duties, traveling with his men and wagon from house to house. He did not lose a day's wages, and in a day or two after resuming work had practically no discomfort from walking about so much. The ankle was restrapped at the end of two weeks.

As to how the cure is effected, Dr. Gibney says: "It has seemed to me that the equable support given to the tendons and ligaments about the joint results promptly in resolution of all effusion, and that the

functions of the tendons and ligaments are thus promptly restored; that use of the ankle is very desirable, and that the cure is brought about by the normal action of the foot."

This method has been very extensively employed in the out-patient department, Hospital for the Ruptured and Crippled, in Dr. Gibney's clinic at the College of Physicians and Surgeons, and in the orthopedic department of the New York Polyclinic.

RESECTION OF THE SMALL INTESTINE FOR TUBERCULAR ULCERATION, FOLLOWED BY RECOVERY.

BY FREDERICK W. HALSEY, M. D., BOSTON, MASS.

February 18, 1893, I was called in consultation by Dr. Walter Whiting, of Malden, to see Mrs. S——, who was suffering from painful fissure in ano. She was just recovering from an attack of typhoid fever, and an operation under ether was deemed inexpedient, hence conservative methods were used. Fortunately the fissure yielded to such efforts and healed. The general condition of the patient did not improve, however, and searching for further cause a thickened doughy mass was outlined, low down in the pelvis of the patient, on her right side. No point of fluctuation was felt; and again, owing to her miserable condition, no immediate operation was advised. Hot salt-water douches were used locally, and arsenicum iodide was advised internally. From then on her condition was that of a chronic invalid, in varying degrees of wretchedness. Shortly after this the family removed to Newton, and the case went into the hands of the other school. Electricity, massage, Christian and mental science were in turn called into service, but without avail. An acute attack of peritonitis developing, she was sent to the Massachusetts General Hospital for operation. After consultation by the surgical staff, an operation was not deemed advisable, the diagnosis being tubercular peritonitis and enteritis, and she was sent home to die. This she refused to do, and to the surprise of her physician and friends she slowly improved until she was able to be up and about once more.

I was now consulted and the patient came to my office for treatment. Her weight at this time was about eighty-five pounds. Examination revealed an indurated and thickened condition in the region of the right ovary and tube, extending well out into the right side, but no distinct tumor could be outlined. An exploratory incision was advised, with a view to the removal of all diseased tissue, if it were found possible. This was declined by the patient. No noticeable change in her general condition took place until July, 1896 (about three years from the date of my first visit to her), when I was again

summoned to visit her, she being then at Winthrop Beach. A fluctuating abscess had developed, under the skin of the abdomen, two inches below and about the same to the left of the umbilicus. The hospital was the proper place for her, and she was removed there that afternoon.

The next morning I opened the abscess (which was very superficial) without ether; pus and blood vented freely. On the third day fæcal matter discharged from the opening, at first in small quantities, but increasing day by day, until almost everything eaten was discharged from this opening within an hour or two from time of taking it. Her general condition was improved at once, the pulse steadying down to 90 or 95 per minute, whereas it had been running from 110 to 115. The temperature also dropped to 99° F., rarely reaching 100° F. at night. Before this vent for the discharge of pus was made the evening temperature never fell below 101° F., and often touched 103° F., and this had been going on for over a year. While this fæcal fistula was a most grievous annoyance to the patient, her general condition showed such a marked improvement that she was advised to wait nearly three months before a laparotomy was attempted.

Dec, 7, 1896, with the kind assistance of Dr. J. W. Hayward, Dr. Boyd etherizing, a laparotomy was made at the patient's home. It seemed probable that the hole in the bowel would be found directly under the fistulous opening in the abdomen. The incision was made in the median line, trusting thus to get under the knuckle of adherent bowel, dissect it free, and repair the lesion. Opening through the peritoneum, no adherent bowel was found at this point. The fistula was followed up; it led obliquely downward to the opposite side of the abdomen, some five inches distant outside of the peritoneum, then dipped down to the very floor of the pelvis, where trouble had been diagnosed several years before; here, after a good deal of difficulty, the lesion in the bowel was found. The abdominal wall was literally riddled with abscesses, running in all directions; these were opened up and cleaned out with the curette. The bowels were adherent to each other, and in many places to the peritoneum, making the dissection and tracing the seat of the disease extremely difficult. The ulceration involved more than two thirds the calibre of the bowel, all three coats of the intestine being entirely destroyed, the ragged hole having a diameter of at least two inches, being oval in shape. The whole bowel at this place for a distance of about eight inches was bound down beyond the possibility of freeing it. Nature's protecting fistulous wall having been freely opened, a resection of the intestine was the only procedure which could save her life. The healthy bowel was grasped firmly on each side of this diseased mass and cut off. An end-to-end anastomosis was now made of the severed ends, using fine black silk and a continuous lembert suture. An extra row of lembert interrupted sutures was then taken outside of the first. Search was

made for other openings in the bowel, but none was found. No tubercles were noticed on the bowels at this time. The ovaries and tubes were quite adherent, but did not seem otherwise abnormal to the touch. The operation had already consumed nearly two hours, and it was not thought best to disturb them. The diseased and adherent bowel was cleansed and left. Drainage tubes were left in the largest abscess cavities and deep in the pelvis, and the wound closed as well as possible.

The peritoneum was found at the point of the fistula, it having been destroyed by the ulceration, and even the skin was put on a severe strain to cover the abdominal viscera. For the first forty-eight hours it was only by the constant attention of a most faithful nurse, together with her own indomitable pluck and determination not to die, that the breath of life was kept in her. From this time on her convalescence was uninterrupted. The abscess cavities gradually closed, the abdominal opening healed, with the exception of the lowest point, where the stitches broke away. A round opening as large as a silver dollar was left, having a distinct communication with the pelvic cavity. From this opening a small knuckle of the intestine could be seen. For fifteen days there was no leakage of fæcal matter. On the sixteenth a small quantity was seen. Nothing more was noticed for a week, then a few specks appeared, and they seemed to ooze out at intervals of about one week. The general condition of the patient had improved wonderfully, but even the occasional appearance of these fæcal specks was a constant menace to her, and the hole into the abdomen was by no means a necessity. It was felt that her condition justified another operation. This was done April 7, 1897.

The abdomen was opened as before, and search made for any opening into the bowel. The point of anastomosis was examined first, and to my great satisfaction it was found to be perfect. Two very small ulcerated spots, at least four feet away from the former disease, were found. These were trimmed a little, and folded in on themselves by lembert suture. The portion of diseased bowel left at the former operation having become loosened by the suppurative process, it was dissected away by the finger and removed. The small intestine was found studded with fine miliary tubercles, over at least a third of its length, these having appeared since the first operation. By making a sliding flap it was now found possible to close the wound completely, one drainage tube only being left. Very little shock was experienced as a result of the operation and the wound healed very kindly. Two or three times a few fæcal specks have been seen on the pad since this last operation, but the inference was that they came from something left in the abdominal cavity before the operation. Six months have elapsed and the patient is up and about her house going out every pleasant day. She has gained thirty pounds and gives promise of staying with us for some time to come.

APPENDICITIS.

BY NATHANIEL W. EMERSON, M. D., BOSTON, MASS.

It is not so very long ago — within the memory of almost everyone here — that it was comparatively rare to operate for appendicitis, and too often then was the operation undertaken as a last resort. If the patient died, those interested had a comfortable feeling that everything possible had been done, and consequently there need be no regrets. How different is it at the present time? In certain cases many of us say "too late" with the utmost regret, because we are certain that prompter measures would have saved the life. A brief retrospect of some of the steps leading up to the present status of the operation among the foremost operators may be of passing interest.

When operation became quite generally advocated by surgeons as the only means of saving life in some cases, there was a storm of protest from a large proportion of the profession. The position of surgery was not clearly defined, because not enough was known of what actually occurred during the process of developing an inflamed appendix. Out of a mass of discussion *pro* and *con* was finally evolved one firm stepping-stone to the practice of to-day; that where pus was present there was nothing to do but operate and give it a vent. And to-day I think it is almost axiomatic that such cases are proper subjects for the surgeon and the surgeon only. This was a decided gain for a proper understanding of all that appendicitis means, and led to much enlargement of our knowledge. It was not long before peritonitis had a new meaning, and we soon came to know that peritonitis — barring traumatism — usually meant in the male appendicitis, and in the female either appendicitis or inflammation of the tubes or ovaries. When this point was once established, how different the view of peritonitis as formerly understood, and how quickly we came to appreciate the enormous death rate of this so much dreaded disease, and the futility of much of the former treatment!

Frequent operation by a great number of operators under widely varying conditions led to the publication of an enormous literature upon the subject, most of it in magazines current during the last fifteen years. Together with repeated operations on pus cases and the almost universal discussion of the symptoms individually and collectively, it was not long before the diagnosis was readily made by the most ignorant of the profession, and indeed even by the laity before the physician was called. Through these means we learned that certain symptoms were almost classical to the disease, and were so much discussed that soon everybody in the profession knew that a sudden attack of violent, persistent vomiting, with exquisite pain in

the abdomen, more often in the right iliac fossa, great sensitiveness to manipulation, and the development of a tumor in this region, together with rigidity of the right rectus muscle, meant appendicitis and nothing else, and that such a group of symptoms was highly dangerous. Also that nature tried to wall off pus as it formed; and that she anticipated its formation by depositing masses of quickly formed adhesions, welding the intestines together and to the abdominal walls, thus effectually shutting in and localizing the focus of pus. In many of these cases the operators found themselves too late. Pus was not only present, but had burst its confinement, and nothing could be done. A few experiences of this kind led the operator to resolve never again to allow a case of such nature, under any circumstances, to go on to extremity, and thus earlier operations were undertaken. These in turn led to increased knowledge of a definite character, and such that the earlier operation was constantly more and more successful. We found the adhesions in process of formation delicate in character and easily broken up; that in the earlier stages of the disease the appendix was more readily and easily enucleated with much gentler manipulation, and that the whole condition was simplified; also, that by operation we cut off instantly the attack, and convalescence was at once substituted. The change is marvelous at times. There is no long-drawn-out convalescence. Had we rested here an enormous advance had been made, but instead of stopping, we were only arriving at the point where we were in a position to gain intimate knowledge of what appendicitis really meant.

We are all familiar with pneumonia, and have remarked what occurs in cases where the acute stage is obviated. Even after the chill we are sometimes able to abort the inflammatory stage. We know we have won a battle, but also know the convalescence will be out of all proportion to the length of the acute stages. In appendicitis this is not so. The patient may be in imminent danger, but extirpation of the cause of offence ends the difficulty, and it is remarkable how prompt is recovery. It seems a purely local affair, even when pus is present. As the appendix is a useless organ in health, when diseased, while dangerous in the extreme, its extirpation involves no sympathetic or compensatory disturbances only so far as the progress of the disease has caused them. The patient is rid of an offender upon whom he is not dependent in health and whom he only misses after its offence.

Instead of discussing any longer pus cases, we were led to discuss the conditions antedating the development of pus and speculating how to forestall it. We soon recognized a class of cases variously called, the term "recurrent" sufficing for our use here; that is, cases which never completely recovered from the initial attack. The patient recovered enough to resume the duties of life, and was comparatively well, and even for short intervals apparently completely restored, but

occasionally and from unknown or trifling causes experienced another and still another attack, until more or less permanently crippled. It then became recognized that such cases were hopeless so far as a complete recovery was concerned, and quite generally was it accepted that after three or four such attacks the best relief was afforded by a removal of the appendix; and waiting for a subsidence of the attack was advised, the operation to take place during an interval. These patients almost invariably recovered after operation. Groups of one hundred and even more of such cases, with no deaths, are reported by several operators — a truly remarkable showing. Would anybody claim that he could take any one of these groups — made up of consecutive and not selected cases — without operation and lose not one?

The literature of the last fifteen years is everywhere punctuated by the oft-repeated statements to the effect that "after four attacks I always advise operation" — "after three attacks the operation alone will afford relief." These operations are all definite advances, marking off stopping places in the development of the individual from which he never recedes. Whenever one sees or hears such a statement he may be certain that it means a conclusion after much speculation along definite lines. But the matter does not yet rest, and one is finally obliged to face the question, "If after three or four attacks we advise operation, why not after two?"

I do not here propose to discuss this question, since it is in itself a subject for a paper of this character, but I am very certain in my own mind that a second attack, even in mildest cases, is a sufficient invitation for interference. This does not question the fact that many such cases get well permanently; but many of them also have a third and fatal attack. Better to operate on many cases which would never have resulted fatally than to allow one such case to be lost. This is especially so since almost invariably, even in the mildest cases, the operation cures the symptoms. It is therefore in any event not without lasting benefit, aside from the permanent elimination of a menace to life. In mild recurrent cases, where we know pus is neither present nor threatened, it is perhaps better to defer operation until abatement of inflammation takes place, because the technique is then simplified. But in severer cases, where pus is already in process of formation or threatened, the time to operate is when the surgeon first sees the case. This conclusion is arrived at, not from speculation, but from actual experience and the lessons taught by it. By prompt interference we anticipate pus, limit adhesions, absolutely interdict the inflammatory process, forestall perforations about which adhesions have not formed, and bring at once to a definite and controlled termination a process over which we have little or no restraint. Also, by promptness, in complicated cases we offer a sure chance of relief. As an illustration of a fortunate outcome in a complicated case by prompt action, the following is cited: a woman was sent to

the hospital with acute appendicitis, the symptoms being well defined. Examination revealed also a uterine fibroid as large as a child's head. The operation was undertaken immediately, and showed a markedly inflamed appendix closely adherent to the tumor, pressure from which may have been the cause of the inflammation. Hysterectomy, together with removal of the appendix, resulted in an uneventful recovery. Had this case proceeded to the formation of pus, as was likely, a complicated operation must have resulted, with at best only a partial relief, and all undertaken with much more danger to life.

Again, a young girl was sent to us as an emergency case. It was a classical reflection of acute appendicitis of severest type. There was persistent and aggravated vomiting, exquisite pain, which began on the right side but was more diffuse when first seen by us; the right rectus muscle was fixed, with a plainly perceptible tumor in the right iliac fossa easily mapped out under gentlest palpation. Besides these characteristic symptoms, there was a high temperature, pulse 110, anxious expression of face, constipation, and tenderness in the right half of the abdomen when moderately deep pressure was made upon the left side. This was one of a class of cases which formerly we left to pronounce itself, or to get over the acute stage, with the idea of operating in the interval. The operation was undertaken as soon as possible after her admission to the hospital, without doubt within an hour of it, and what was found justified the good judgment of such a step. The intra-abdominal mass was adherent to the abdominal wall, and was composed of intestines and omentum firmly agglutinated yet easily separated from each other, a line of cleavage always being readily found. Deep in the abdomen and behind and to the inner side of the cæcum was found a very much enlarged and angry appendix, acutely inflamed throughout, with two points upon its originally free border undergoing a process of gangrene and inevitably sure to have ruptured in from twelve to eighteen hours more if left to themselves. They were already black, of the consistency of soft soap, and separated from each other by perhaps one half inch of highly inflamed tissue. The adhesions were so thorough in this case that probably a large abscess would have resulted, confined in such a way that the abdominal cavity would not have been involved. Yet this is as purely conjecture as it would have been to have allowed the case to go on awaiting an "interval." From the violence of the symptoms it could easily and quickly have continued to a general septic peritonitis.

In any event an operation would have been necessary in two or three days to evacuate pus, and we should have had a slow and tedious convalescence at best. By attacking it when we did, no difficulty was experienced in removing the whole appendix intact and securing primary closure, with the result that the temperature was normal the next morning and all acute symptoms had disappeared. Convales-

cence was immediate and uneventful. It is a rule, not alone with us, but several others of the staff at the hospital, to operate on such cases immediately upon receiving them, and every time we do it our judgment is confirmed and we are more eager to so treat the next case.

The best method of treating the stump of the appendix is Dawbarn's, and after trying the several methods most in use this is now invaribly employed when possible. After tying off the meso-appendix and isolating the appendix where it joins the cæcum, a fine silk is passed, by means of an ordinary sewing needle, about one quarter to three eighths of an inch from the appendix in such a way as to surround the base. The suture is placed like a basting thread and passes in and out of the muscular layer of the intestines. The appendix is now cut off about one half inch from its base, the stump dilated, and then inverted into the intestine. While held here the silk is drawn tight and tied. The result is a complete turning of all appendix remains into the bowel, and the bringing together of peritoneal surfaces in such a way that adhesion must take place. After the silk is tied and cut short, a very fine catgut is passed as a continuous suture from the mutilated meso-appendix on to the intestine, including only peritoneum, and covering in the site of the appendix. This method is far ahead of simply ligating the appendix, cutting it short, treating the stump with carbolic acid, and covering it with a cuff of peritoneum.

Also, there is at present more uniformity in closing the wound, better results being attained from suturing each layer separately. This is more often done now since hernia is less likely to follow. It seems a natural procedure since the different layers of the abdominal wall are so well defined and easily found. Save in some pus cases, hernia is not necessary.

THE SURGICAL TREATMENT OF DIPHTHERIA, WITH REPORT OF CASES.

BY J. EMMONS BRIGGS, M. D.

In glancing over my record of operations for diphtheria I am appalled by the high rate of mortality, and I am more than ever impressed with the fatality of this disease. (If I had had opportunity to handle hundreds of these cases instead of the very meagre number which it has been my lot to treat, it is quite possible that the average rate of mortality would be perceptibly reduced, at least I hope such would be the case. As it is, I feel convinced that very hopeless cases have fallen into my hands.)

I am persuaded to give you the result of my experience, hoping that we may gain some light and arrive at helpful conclusions which

will prove of benefit in the treatment of this disease. Since the advent of antitoxine the mortality has been perceptibly reduced, but to what extent it is impossible to judge with accuracy. Time only will tell, and further experience with numerous epidemics will be necessary before its true value can be estimated.

In the surgical treatment of diphtheria we have at our command two operations for stenosis of the larynx, tracheotomy and intubation. There is at present no question which of these operations should be performed. We should *always* intubate. If this does not give relief, owing to the deep-seated location of the obstruction, then it is warrantable to perform tracheotomy. Yet when intubation is unsuccessful in diphtheria it is almost a forlorn hope to expect tracheotomy to accomplish anything, although in a report of 7,963 cases* of intubation and tracheotomy, tracheotomy was performed seventy times after intubation had failed, with eleven recoveries, or the saving of one life in 723.

When should intubation be done? Just as soon as there is any obstruction to the respiration. Many lives are lost by delay. It is almost universally the case that by the time the surgeon is called the child is cyanotic and many times moribund. Vital forces which are sorely needed to fight the toxines of the disease are expended in the unnecessary effort at respiration. Not only is strength and vitality consumed, but the excess of carbon dioxide in the blood caused by the impairment of respiration produces its effect upon the system, the pulse gets very small, rapid, and irregular, and if stenosis is not relieved, mild convulsions and death ensue.

The operation of intubation is easily and quickly done, requires no anæsthetic, no cutting, and causes no deformity. The consent of parents is readily obtained. The relief is usually instantaneous and satisfactory.

The steps in the operation are as follows: the patient, if a child, should be wrapped in a sheet and supported in the arms of an attendant. Its head should be on a level with the attendants shoulder, turned slightly backward and supported by an assistant. The gag should be inserted between the molar teeth on the left side and given to the assistant to hold in position. The operator, after selecting the tube adapted to the child's age and size, proceeds to thread a piece of braided silk about a yard in length, through the eye of the tube. With the tube in position on the obturator, and standing in front of the patient, he inserts his left index finger in the child's mouth deep down in the pharynx, brings it forward in the median line, raising the epiglottis. He then depresses the handle of the introducer so that the point of the laryngeal tube comes in contact with the index finger, and by elevating the handle of the introducer, and keeping the tube in

*Sajous' Annual, Vol. 1, H 38, 1894.

contact with the finger, it slips into the larynx without difficulty. The tube should then be pressed carefully into position, and by pushing a slide in the handle of the introducer the obturator detaches itself from the tube and is withdrawn. If the tube be well adjusted in the larynx the dyspnœa is immediately relieved ; but if there is no improvement one of three things has happened — either the tube is not within the larynx, or it has pushed down membrane and it has occluded the lumen of the tube, or it is possible that the stenosis is lower down than the larynx. In any case the string which is attached to the tube should be pulled upon and the tube extracted, and another attempt made to adjust the instrument. After a little experience the operation can be done easily in from two to five seconds.

In the feeding of the intubated child great care is necessary lest food enter the trachea, which would be liable to prove fatal. Semi-solids are best taken either by the child lying upon its back with the head turned slightly to one side, or by feeding by means of the nasal tube. This latter method I have found very useful. A tube is passed through the nostrils, pharynx, and œsophagus to the stomach. A funnel is attached to the end of the tube and food administered in liquid form. Food can also be given in the form of rectal enemata.

Of late it has been my custom to nourish the child entirely by nasal and rectal feeding. As the tube can usually be removed within four days the child does not suffer from this method.

REPORT OF CASES : — Case 1. N., female, aged six years, was operated upon October 3, 1894, for laryngeal diphtheria. Four days previously she began to suffer from general malaise and sore throat. I saw her with the attending physician October 1, at which time a diphtheritic membrane was to be seen on either tonsil. She complained of considerable backache, and there was profound general prostration. She was treated medically and received local applications of peroxide of hydrogen at frequent intervals. On the morning of October 3, it was evident from the breathing that the membrane had commenced to encroach upon the larynx. This condition continued to grow more marked, until by evening dyspnœa was profound. I was summoned about nine o'clock in the evening, and upon arriving at the patient's home found the child quite cyanotic and laboring profoundly in respiration. A small amount of ether was administered and a tracheotomy tube placed in position. The child stopped breathing as the external incision was made, and the rest of the operation was done as expeditiously as possible and resort was had to artificial respiration. The child revived, and the relief obtained from the operation was most gratifying. On the morning following the operation her condition seemed to be more promising and we had very strong hopes that the worst had passed. At about six o'clock she was taken suddenly worse and expired within an hour. Death, no doubt, was due to paralysis of the heart and general toxæmia.

Case 2. C., female, aged four years, was intubated December 7 and 8, 1894. The child had been ailing for several days, but was taken suddenly worse December 5. The case progressed as usual until on December 7 symptoms of laryngeal stenosis became pronounced. Her breathing was very labored, and her face deathly pale I immediately introduced an O'Dwyer tube into the larynx, which was followed by only partial relief, owing no doubt to the fact that membrane from the larynx was pressed downward ahead of the tube. Within a few moments the child coughed violently and expelled the tube with a considerable quantity of membrane. This was followed by partial relief, enough so that it was deemed best not to reinsert the tube. I remained with the patient all night, and seeing no necessity for the reintroduction of the tube, returned to my home early in the morning. Everything went fairly well as regards respiration throughout the day, but the evening brought on a recurrence of the dyspnœa, which was even more pronounced than on the previous night. I was again summoned in great haste by the attending physician, and upon arriving at the house found the child in a very critical condition. I again attempted to intubate the child. This time there was no improvement with the tube in position, in fact there was an additional obstruction, so that I was obliged to withdraw the tube quickly lest the child suffocate. Another attempt was made, but with the same unfavorable result. There remained now only one hope for the child's life, and that through tracheotomy, which was performed. The result of this operation was no more satisfactory than intubation had been. No relief from the dyspnœa resulted and the child died within an hour.

Case 3. F., female, aged fourteen months, was intubated December 18, 1894. The child was taken ill two days previous, having grown gradually worse until the time I was summoned at five P. M., December 18, when respiration was rapid and exceedingly labored. No membrane was to be seen in the pharynx. Intubation was immediately performed, and complete relief from dyspnœa ensued. The child was fed by the nasal tube, and resort was had to calomel sublimation. The child lived four days after the operation, and during this time there was no recurrence of laryngeal stenosis. Death was caused by a capillary bronchitis, which made its appearance on the third day after operation.

Case 4. C., male, aged two years, was intubated January 4, 1895. This child had been ailing for some days, but the case was not considered serious until dyspnœa became marked about twelve hours before the operation was performed. When I arrived the little patient was suffering profoundly from dyspnœa, and I intubated immediately. The relief obtained was instantaneous and perfectly satisfactory. The child died on the next day of capillary bronchitis or pneumonia.

Case 5. H., male, aged seven and one half years, was intubated November 24, 1895. The patient had been ailing for one week with general malaise. Two or three days previous to the operation he began to complain of a sore throat, and a diphtheritic membrane was discernible upon the tonsils. At the time of the operation the diphtheretic exudation had entirely disappeared. His temperature was 100, and his pulse 110. During the preceding twenty-four hours he had had several very violent attacks of choking. One of these seizures was so severe that his physician thought he would surely succumb. This case differed from the preceding cases in that the dyspnœa seemed to be paroxysmal, while at times his respiration was not very labored. The laryngeal tube was introduced, which gave him entire relief. I was in daily communication with his physician, who reported each day an improvement in the child's condition, and on November 27 reported him as convalescing satisfactorily. On November 29, as I was making preparation to leave my office to remove the tube, his physician called and told me that while playing with his toys in bed that morning he suddenly fell upon his face dead. His death was, no doubt, attributable to paralysis of the heart.

Case 6. B., female, aged three years and nine months, was intubated January 28, 1896. Three days before the operation the child began to be hoarse. On the day following she was somewhat improved, but in the evening grew worse again, and during the night dyspnœa became pronounced. When I arrived she was breathing with extreme difficulty. The introduction of the laryngeal tube gave her absolute relief. The case progressed satisfactorily, with no recurrence of obstruction to respiration. On February 2, five days after the operation, I removed the tube. The child made an uninterrupted recovery.

This was the first case in the series to receive antitoxine.

Case 7. M., female, aged two and one half years, was intubated January 31, 1896, at five P. M. She had been ill for several days, but was not considered in a precarious condition until the day of the operation. When I arrived dyspnœa was very pronounced, the child very cyanotic and in fact moribund. Temperature was 105°, and pulse practically imperceptible. The introduction of the tube relieved the dyspnœa, but within an hour's time brain symptoms developed and she died at nine o'clock, four hours after the operation.

Antitoxine was administered in this case some two hours previous to the operation.

Case 8. M., male, aged eight years, was intubated on March 15, 1896. Seven days previous he was taken ill with the measles, and was convalescing until March 14. At this time he was suddenly taken worse, respiration became difficult, his temperature rose to 101°, and pulse 120. At the time of operation the respiration was exceedingly labored, and cyanosis very marked. The laryngeal tube was placed

in position and gave him great relief. During the night following he expelled the tube, which was reintroduced by a physician near at hand. The boy made an excellent recovery. Antitoxine was given in this case, immediately after intubation.

Case 9. H., female, aged seven, was intubated on June 17, 1896. The child had been ailing for nearly a week, but her condition was considered as whooping-cough until about three days before the operation. At that time symptoms of stenosis of the larynx were noticed, and dyspnœa became more and more marked, until at the time the operation was done she was breathing with great difficulty. At this time no diphtheritic exudation was discernible on the pharynx. A culture was made from mucus from the larynx, which Professor Ernst reported as containing the bacilli of diphtheria. The introduction of the tube gave her great relief. During the forenoon of June 18, she received antitoxine, but she sank rapidly and died at ten P. M. of the same day from septic infection produced by the diphtheritic toxine.

Case 10. E., male, aged four years and four months, was intubated November 29, 1896. The boy was taken ill three days previously, with what seemed to be a cold, accompanied with some catarrhal discharge from the nose and slight sore throat. For twenty hours symptoms of obstructed respiration had been present. When seen by me his temperature was 101°, pulse 152, respiration varying from 32 to 45 per minute. The insertion of the tube was followed by complete relief from dyspnœa, which did not recur. The tube was removed on December 3, having remained in the larynx four days. The patient made a satisfactory recovery.

Antitoxine was given in this case six hours before intubation was performed.

Case 11. C., male, aged three years and four months, was intubated December 13, 1896.

The patient had been ill six days with an attack of what was called acute indigestion. Following this his throat became sore, and he grew worse daily. Difficult respiration had been present twenty-six hours. His temperature at seven P. M., when intubation was done, was 101°, pulse 110, and respiration 30. The operation was followed by entire relief from dyspnœa. His record afterward was interesting and his condition seemed most hopeful up to within a few hours of his death. He was fed frequently with a nasal tube. His temperature reached 102° on the night following the operation, then gradually fell until it reached normal, where it remained until the afternoon of his death. On December 19, the sixth day, the tube was removed but his respiration soon became labored and it was replaced. Two days later, December 21, it was again removed and the breathing remained normal. On the day following, December 22, he became rapidly worse, his temperature was 104½°, pulse 130, and respiration very rapid and panting in character. Crepitant rales were to be

heard on the entire right lung. The tube was reintroduced, but as it gave no relief was immediately withdrawn. He died at nine P. M., December 22, nine days after the operation. Here is a case where death occurred after the child had apparently passed all danger. His death was from pneumonia, which was, without reasonable doubt due to the lodgment of food in the right bronchial tube, which acting as an irritant set up a traumatic pneumonia.

Case 12. Y., female, aged three years, was intubated December 26, 1896.

The child was taken sick four days previously with sore throat and general malaise. White spots were discovered on the tonsils, but they disappeared after local treatment had been instituted. For twenty-four hours respiration had been very labored, varying in frequency from 35 to 50 per minute, pulse exceedingly irregular and rapid. The introduction of the tube reduced the respiration to 22, and relieved all dyspnœa, from which she did not again suffer. She died forty-eight hours later from general septic intoxication.

Case 13. G., female, aged two years and six months, was intubated February 16. 1897. For a week the child had been ailing. Dyspnœa had been marked for twenty hours. At the time of the operation the respiration was 60 per minute and pulse 164. The introduction of the tube was followed by relief from dyspnœa, and the respiration soon fell to 30 per minute. The child was *in extremis* at the time the operation was performed, and died seven hours later from paralysis of the heart due to absorption of septic ptomaines.

Case 14. B., male, aged seven years, was intubated March 6, 1897. This youth had been ailing for several days, sore throat and general symptoms of diphtheria existing. He had had much difficulty in breathing for twenty-four hours, at the time of operation dyspnœa being intense. He obtained great relief from the operation, and his case progressed favorably for thirty-six hours, when pneumonia developed and he died.

The pleas which I shall enter in defence of so high a rate of mortality are:

1. Laryngeal diphtheria is the most fatal form of the disease. Strumpell,* in speaking of it, says that recovery is possible, but that unfortunately this happy termination rarely occurs.

2. The severe character of the cases treated. Of the fourteen, all would have died within a short time from suffocation had not operative treatment been employed. And furthermore, all of the patients were entirely and lastingly relieved from dyspnœa with the exception of Case 2, where intubation was performed, followed by tracheotomy. This case received only partial and transitory relief from intubation and absolutely none from tracheotomy.

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* Text-Book of Medicine, Strumpell, page 68.

It could not be expected that the statistics compiled from any surgeon's private work would compare favorably with the work done at any of our hospitals where diphtheria patients are treated. In private practice the surgeon is rarely called until the patient is practically exhausted, having suffered from dyspnœa anywhere from six to twenty-four hours, while in any hospital intubation would be performed immediately upon the appearance of difficult respiration. This point alone is sufficient explanation for the greatly superior results obtained in hospital practice.

The most important point which should be impressed upon physicians is, that it is of the utmost importance to intubate just as soon as dyspnœa appears. Humanitarianism demands the relief afforded by this operation. It should be resorted to even if it is probable that the child's life cannot be saved. Any one who has seen a death from suffocation must have witnessed a sight he may pray to be delivered from beholding again. In order to accomplish the best results every physician should acquire sufficient knowledge to enable him to intubate his own cases. By so doing he will be able to insert the tube upon the first appearance of laryngeal stenosis. Bear in mind that intubation is not an operation *per se*, it is simply a mechanical contrivance to relieve stenosis of the larynx, and will not in any way interfere with the after treatment of the case. In other words, it gives the physician time to use his remedies by postponing imminent danger of suffocation. It will not cure the patient of diphtheria, but may give time to institute treatment which will.

PROSTATIC ENLARGEMENT.

BY HORACE PACKARD, M. D.

Introduction. It is not the purpose of the writer in this paper to present an exhaustive study of diseases of the prostate gland, but only to present for your consideration the results of personal observation upon both local and general conditions which result from obstructed flow of the urine through increase in prostatic tissue. I scarcely know of a disease of advanced years of manhood which appeals to one's sympathy so forcibly as this one under consideration. It occurs in men past the heyday of life, and often in those who have followed in every respect a temperate and exemplary course, and as a result of business industry are in financial circumstances to look forward to an old age of comfort and luxury.

The advent of prostatic enlargement shatters all these attractive visions, and as a result we as physicians are called to deal with cases of physical and mental wreck ; physical, because the local condition

and its sequelæ rapidly exhaust muscular strength, tie the patient up within the small compass of his immediate environment, and he dares not venture beyond it, unaccompanied by his catheter. Finally, he fails in his efforts to void his urine even with this help, and his misery is complete. He becomes mentally a wreck, because night and day he cannot thrust from his mind the consciousness of local discomfort and frequent calls to evacuate his bladder, which are incomplete and unsatisfactory, and as a result, no matter in what line of art or literature his inclination may lead him to seek congenial occupation, his thoughts are continually diverted by the inexorable demands of his urinary organs.

Clinical Picture. A man in the sixties, otherwise in good health, gradually becomes conscious of impediment in voiding his urine. The urinary stream, instead of being freely and forcibly ejected from the body, falls straight, or nearly so, to the ground. For a time this produces no trouble except prolonging the act. After a time, possibly the lapse of months, the patient becomes conscious that the bladder is not entirely evacuated with each attempt. He makes effort to fully empty the bladder by voluntary straining. With all his efforts there are still always a few more drops to come. The interval between the acts becomes reduced from three or four hours to an hour or two. All this is the result of the accumulation of residual urine within the bladder, that is, the enlarging prostate has gradually encroached upon the urethral canal until the obstruction to the free flow of urine through the urethra is so great that the contractile force of the muscular walls of the bladder is insufficient to empty it. There now occurs one of two conditions. Either the calls to urinate become vastly more frequent, until the patient has no peace night or day, or there is a constant dribbling, beyond his control, which keeps him wet and in discomfort all the time. The former of these conditions is a result of the frequent, yes, almost constant stimulation of the muscular walls of the bladder to contract, with actual hypertrophy of the muscular tissue, great thickening, and with corresponding diminution in the capacity of the organ. It has come to the condition where it can contain but a few ounces of urine, is never empty, and is always in a state of contraction, seeking to force out its contents through the obstructed urethra. The latter state is the result of almost total lack of tone to the bladder wall; in other words, it has offered little or no resistance to the dilating tendency of the accumulating residual urine. It becomes stretched and distended to its utmost limits, rises high in the abdomen, even to the umbilicus. As long as the urethral channel is pervious, the urine constantly dribbles away, drop by drop. These patients become singularly tolerant of this distended condition of the bladder, and often wonder why it is that, though they are constantly passing urine, there is always more to follow. Usually before the stage above outlined is reached, the patient has been provided with a

catheter, either through his medical adviser or through some friend similarly troubled. Between the times of using he either keeps it in common with divers other toilet articles in a convenient drawer, or, when out and about, coiled up in his coat pocket. Through ignorance, little or no attention is paid to the simplest principles of surgical cleanliness; hence infective matter is carried into the bladder, fermentation of the residual urine follows, with cystitis and all its attendant sufferings. The voided urine becomes extremely offensive, the constant pain of cystitis is added to the urgency for urination, and finally, as a last added torment to harass the afflicted patient, the presence of stone is discovered in the bladder, and he is subjected to litholapaxy or supra-pubic incision for its removal.

Pathological Changes. I will ask your attention briefly to the normal structure of the prostate gland as affording the simplest introduction to the pathological changes which occur. It has a limiting fibrous capsule, a framework of connective tissue. Its mass consists of smooth muscular fibre, and penetrating its substance are mucous glands. It surrounds the urethra at its vesical end for about an inch and a quarter of its length.

We thus find in this organ structures which give rise to the possibilities of enlargement, through hyperplasia of the connective tissue (single or multiple fibroid enlargement, quite comparable to fibroids of the uterus); through increase in the smooth muscular tissue, which is usually diffuse, but may involve unequally the different parts of the gland, thus making one lateral half or lobe greatly in excess of the other, or affecting, it may be, exclusively the middle portion or lobe, and infringing directly upon the urethra; again, through increase in the glandular tissue, resulting in the formation of adenomatous growths, and since these glands are located in the posterior and lateral parts of the organ, enlargement therefrom, if diffuse, results in increase of the mass of all the lateral and posterior portions, displacing the urethra forward, and pressing upon it laterally. It is desirable to bear in mind that in the connective tissue we have the possibilities of origin of sarcoma, and in the glandular tissue of carcinoma. It is comparatively rare that malignant enlargement of the prostate occurs, but in cases of rapid increase in size of the organ, the possibility of such should be considered.

The pathological changes in the gland itself then are briefly: —

1. Enlargement from fibroid tumor formation, single or multiple.
2. Enlargement from diffuse increase of the smooth muscle fibres, which may be a true hypertrophy.
3. Augmentation of the glandular structure, constituting adenoma.
4. Carcinoma.
5. Sarcoma.

The physical changes which may result from any or all of these are encroachment upon the urethra.

This is usually the first intimation which the patient has of trouble of this origin, and may exist a long time without resulting in sufficient obstruction to seriously impede the voiding of the urine. If rectal examination be made at this time, the convexity of the prostate gland, which can be readily felt with the tip of the index finger through the rectal wall, is found increased symmetrically or irregularly according to whether there be diffuse enlargement or localized tumefactions. The enlargement may have progressed until, as the finger sweeps over the convexity, it may convey the impression that almost the whole pubic arch is filled with the growth. There comes, sooner or later, distinct diminution in the force with which the urinary stream is ejected. It runs in a sluggish stream and falls straight from the body. This indicates that the resistance at the constricted portion of the urethra, that is, where the prostate is impinging upon it, is so great that the bladder muscle is no longer able to efficiently expel the urine. Now after each attempt at micturition a portion of urine is still left within the bladder — residual urine. This condition may go on a long time, and be partly compensated in robust individuals by increase and thickening of the muscular walls of the bladder, with correspondingly increased power of contraction and expulsion. In patients of lax fibre and little reactive force the bladder wall dilates, thins, the urine is expelled with less and less vigor, there may be separation of the fibres of the muscular coat, permitting hernia of the muscular coat and sacculation. As the residual urine increases, and the bladder becomes distended and the intra-vesicular pressure increases, the urine slowly dribbles through the urethra as long as its calibre is in any wise pervious. There is a singular absence of the urgency to urinate, which would be assumed to exist in such cases. Often such cases will go about for a considerable time with an amount of residual urine distending the bladder until it reaches the umbilicus and forms a well marked fluctuating tumor, filling the umbilical and hypogastric regions. Urine is dribbling at all times from the urethra, keeping the patient constantly soiled. About this time, usually, the true condition is discovered and a catheter is resorted to for periodical evacuation of the bladder. From lack of care of cleanliness in the use of the instrument, fermentive material is carried in, and promptly putrefactive decomposition is established, with its sequel, cystitis.

The mucous walls of the bladder become injected, thickened, sensitive, raised in rugæ, sacculated; the same process creeps up the ureters to the kidneys, and we finally have the whole urinary apparatus involved in this diseased condition,— pyelitis, ureteritis, and cystitis,— all originating from a primary enlargement of the prostate. As the condition goes on and the congestion incident to the inflamma-

tion of the urinary tract increases, the pain centres chiefly about the base of the bladder, and may be felt also in the penis. The quantity of urine becomes increased and of low specific gravity, partly from advanced age and partly from deterioration of the function of the kidneys. Tube casts are occasionally found, the urine becomes intensely foul, with an abundance of pus and blood. Usually these cases do not fall into the hands of the surgeon until the gravity of the symptoms has reached the stage above described.

Treatment. In cases of enlarged prostate, treatment is usually not sought until the exigencies are so great as to call for artificial aid in evacuating the bladder, and usually this is the catheter. It is against the too early and indiscriminate use of the catheter that I wish to protest. I think it is not too extravagant to estimate that nine tenths of the discomfort and misery in prostate cases results from ill-advised catheterization.

How may relief be given without this? In the first place seek to keep the urethral channel open as widely as possible through the daily use of steel sounds which have been boiled previous to each sitting, to insure absolute sterility. Teach the patient not to try to urinate in cold or exposed places, but always in a warm room, preferably before an open fire. It is almost a foregone conclusion that if these aged sufferers stand with bare feet upon a cold floor or go out of doors, the act will be a failure.

Teach them to wear suitable clothing for the limbs and feet, to avoid chill and dampness. A hot sitz bath taken in a warm room before an open fire immediately after the seance with sounds will often enable the patient to fully evacuate the bladder before retiring for the night. Advise against the free use of fluid drinks in the latter part of the afternoon and evening.

See that the patient takes an abundant supply of pure water in the early part of the day. Establish a simple but nutritious diet, and if he be wakeful in the early morning hours arrange for him to have a simple lunch like a glass of milk and a biscuit. The following of these simple rules will, I believe, in every case delay the use of the catheter indefinitely and save your patient the misery of pyelitis, cystitis, and calculus, and the great dangers accompanying operations upon these aged subjects.

As internal remedies there are two only upon which I place reliance. Boracic acid given at intervals, for example, five grains daily continued a week and then wait a week. The other is argentum nitricum, which I administer in the 3 x three times a day for a month, then wait a month.

The surgeon, however, rarely has an opportunity to treat these cases from the beginning. The condition when they seek his advice is usually such that operative measures must be employed. Since the enlarged prostate is the primary cause of all the trouble, naturally the

question arises, "Can it in any safe way be removed or reduced?" The simplest and perhaps the safest procedure for our consideration at the present time is

Castration. This proceeding, recommended a few years ago by Dr. J. William White of Philadelphia, has now been resorted to a sufficient number of times to test its efficiency. If we may place credence in reports now available we must believe that a very large percentage experience marked improvement after this is done. We have to bear in mind that reports also show that there are occasional unpleasant mental after effects, such as melancholia. How castration brings about atrophy of the gland we are unable to explain. It appears to be analogous to the atrophy not infrequently observed in uterine fibroids after the climacteric or removal of the ovaries. A more radical measure and one involving greater danger to the patient's life is

Enucleation and Removal of the whole Gland. This may be accomplished most readily through a combined perineal and supra-pubic incision. A transverse incision across the perineum in front of the sphincter ani enables the operator to reach the prostate fairly easy. Make a transverse suprapubic incision and carry the forefinger of the left hand into the bladder down to the prostate. Now with the forefinger of the right hand in the perineal wound, the gland is enucleated more readily and more thoroughly than in any other way.

It must be borne in mind that this operation should be recommended with great reserve, for these aged patients bear such severe operations poorly. In violent cystitis, with urine bearing much pus and blood, *perineal drainage* may be the expedient called for, although it leaves the patient ever after with total incontinence of urine. If stone in the bladder exist, *litholapaxy* or *supra-pubic cystotomy* may be required.

Conclusions. First, Indiscriminate catheterization is a menace, yes, a positive injury to patients with enlarged prostate.

Second, Through simple measures the majority of prostate cases may be tided along through years of comparative comfort if taught the dangers of the catheter and shown how by proper hygienic measures to care for themselves.

Third, Operative measures are poorly borne by these aged and usually decrepit patients.

Fourth, Castration offers the simplest means of affording relief and is usually efficient if resorted to early.

Dr. Krebs reported a case to illustrate the value of manipulation in cases of sprain.

REPORT OF COMMITTEE ON GYNÆCOLOGY.

CLARA E. GARY, M. D., *Chairman.*

I. Remarks on Gynæcological Surgery. Alonzo Boothby, M. D. Discussion: Frank C. Richardson, M. D.
II. Technique of Vaginal Hysterectomy. Nathaniel W. Emerson, M. D. Discussion: J. K. Warren, M. D.
III. Extra-Uterine Gestation: Report of a Case. Augustine C. Haub, M. D. Discussion: Horace Packard, M. D.
IV. The Value of Gynæcological Electro-therapeutics. Clara E. Gary, M. D. Discussion: W. J. Winn, M. D.

The only paper in this Bureau forwarded for publication is the following:

THE VALUE OF GYNÆCOLOGICAL ELECTRO-THERAPEUTICS.

BY CLARA E. GARY, M. D., BOSTON, MASS.

It is not the purpose of this paper to depreciate the brilliant achievements of gynæcological surgery during the past half century, but to illustrate by cases, gathered from private practice, the curative action of electricity applied to diseased organs.

Drugs (indispensable in certain conditions) prove alluring and deceptive to the discouraged physician, and in many cases a positive failure. Then the surgeon is consulted. In the mad rush for pre-eminence the young operator, and the older ones for that matter, avail themselves of the knife as a swift panacea for obscure pelvic disorders, and we have a vast army of women launched upon life without their generative organs, but with an unintelligible amount of symptoms of the same character that made their lives miserable before they lost their womanhood. In case number one we have much to do with the nerve supply of the pelvic organs. For this reason it may be well to recall their location. The inferior hypogastric plexus is situated at the side of the rectum, vagina, and bladder. These plexuses are in turn derived from the hypogastric plexus of the sympathetic, situated in front of the promontory of the sacrum. Therefore we have the vaginal plexus supplying the walls of the vagina, the uterine plexus supplying the cervix and lower part of the uterus, and other filaments passing separately to the body of the uterus and Fallopian tubes.

Case 1. Mrs. A. B. W., age thirty-seven years; married eighteen years; two children, youngest sixteen years. Cervical laceration at the birth of the youngest. Not repaired for six years. As a prob-

able result nervous symptoms began to develop. Operation. Patient recovered. Shortly after recovery she had a fall. Did not fall heavily, but had, as she termed it, "a terrible shaking-up." Nervous symptoms returned. Intense pain in the region of the sacrum. Went to a specialist in nervous diseases. He referred her to a surgeon. Examination revealed a retroverted uterus with uterine and right ovarian adhesions. The adhesions were broken up and uterus placed in a proper position, supported by a pessary. Nervous symptoms continued to increase. Constant pain in back and abdomen. Painful menstruation. Stomach refused food. Patient despondent. Again consulted a surgeon. After carefully examining the case he advised hysterectomy. Patient recovered from the operation, but with increased nervous symptoms. She came to my office December 15, 1896. It was impossible to gain any connected account of her case at that time, except that she had been operated upon and was steadily growing worse. The physical examination revealed no objective symptoms, except great tenderness over the lower part of the spine. Gave her static electricity over the lumbar region. Used the mild spark or counter irritant. After every treatment she declared that she felt stronger and better for a few hours. Then there would be a return of the nervous symptoms for a short time. After eight sittings, embracing a period of three weeks, discharged patient. September 25, 1897, she came to my office to say that she had had no return of the nervous symptoms since the last treatment, which was in January. There seemed to be a loss of nervous equilibrium (if I may use the word) on account of the long-standing laceration. The removal of the pelvic organs did not relieve but aggravated the trouble.

Case 2. Mrs. M. T. came to my office February 4, 1897. Had previously been examined by two surgeons, who advised hysterectomy. Patient thirty-four years old; married twelve years; no children. Excitable temperament. Symptoms, dull, heavy pain in the ovarian region while walking, especially in the left side, increased by standing. Pains running down the thighs and across the sacrum. Defecations painful. Irregular menstruation. Examination necessarily imperfect on account of the great hyperæsthesia of the parts. It was sufficient, however, to diagnose an enlarged uterus with a hyperæmic condition of the surrounding tissues. Advised electricity before resorting to the more heroic treatment offered by the knife. February 4 applied vaginal bipolar faradization to lessen the tumefaction, congestion and pain. To avoid painful contractions and to attain the requisite degree of tension from the secondary coil, I used a very fine wire of great length, making smooth vibrations. Treatment occupied about twenty-five minutes. February 5, 6, and 7 same treatment, marked improvement. February 8 substituted the galvanic current, strength fifteen milliamperes, for ten minutes. Positive pole (carbon

clay-covered electrode) in the vagina, external electrode over the lumbar region. February 9, same treatment. February 10, patient complained of a great amount of pain. Return to the bipolar faradization for ten days. February 21, same treatment, using a coil of shorter wire. Continued this treatment until March 1. Menses appeared at the proper time with a diminished amount of pain. Defecation improved. March 11, substituted the galvanic current, twenty milliamperes, about twelve minutes, with the positive carbon plate-covered electrode in the vagina. Continued this treatment for twelve days. Repeated examinations led to the above changes. Discharged the patient well. To prove that my premises were correct, I requested the opinion of some other physician. Accordingly, April 4, the patient was placed under an anæsthetic and critically examined by a prominent Boston surgeon. He pronounced the uterus and right ovary perfectly normal. The left ovary could not be outlined, as the tissues were hardened and thickened on that side. Patient informed me that she was made aware of this condition several years ago, while she was being examined for sterility. September 25, Mrs. M. T. reported at my office that she had been comparatively free from pain, no trouble at the menses, in fact she informed me that she had passed a most "delightful summer."

Case 3. Neuralgic dysmenorrhœa. Miss H. L. M., age thirty-two; began to menstruate at fourteen years. Not regular the first year. Became so after that. The flow generally lasted seven days. For the last four years her periods have been terrible during five days out of seven in every month. Has been obliged to remain in bed the whole of that time. She would hardly recover from the prostration of one period before the next one was due. Three years ago a surgeon performed rapid dilatation. For five months suffered comparatively little pain. In March, 1895, a very painful period, compelling her to go to bed for two days. In April suffering more intense, keeping her in bed the entire week. Surgeon again performed rapid dilatation. May and June her periods were extremely painful. Pelvic examination with negative results. Patient thoroughly discouraged, and as the only possible relief submitted to the extirpation of both ovaries. The flow gradually diminished, but the pain became constant and increased in severity. September 12, 1896, she came to my office. Gave her internal applications of the galvanic current, about thirty milliamperes. Continued this treatment every third day for four weeks. The paroxysms rapidly yielded. March 10, 1897, dismissed patient cured, as she had been free from pain since the last of January, 1897. September 25, 1897, she reported in my office no return of former symptoms.

Dr. Rockwell says very truly: "If an agent like electricity possesses such marked influence over so many forms of pain of obscure origin, why should not this treatment *precede* rather than *follow* operative proceedings for their relief?"

REPORT OF COMMITTEE ON DERMATOLOGY, SYPHILOLOGY, AND GENITO-URINARY DISEASES.

JOHN LAMBERT COFFIN, M. D., *Chairman.*

I. Electrolysis in Urethral Stricture. Orrin B. Sanders, M. D. Discussion: Edward P. Colby, M. D.
II. Spermato-Cystic Disease. James Krauss, M. D. Discussion: S. H. Blodgett, M. D.
III. Skin Lesions in Tertiary Syphilis. A. H. Powers, M. D.
IV. Digestive Disturbances as a Cause of Adult Eczema. John Lambert Coffin, M. D.

USE OF ELECTROLYSIS IN URETHRAL STRICTURE.

BY ORRIN B. SANDERS, M. D.

There are many extreme enthusiasts in medicine and surgery who claim that their special hobby is a cure-all for every deformity or distortion of the human frame; as an example, the orificialists, who claim, not only that a certain percentage of the ills of humanity can and are cured by their procedure, but that all ailments, if treated by them, would result in marvellous cures like bombshells. But, gentlemen, while orificial work has its place in medicine and, in my opinion, a very commendable place, a conservative ground is the only tenable one for them. So in many other special lines of work, because the extreme enthusiasts extol it so loudly and carry it to such a farcial degree that the average practitioner becomes disgusted with the absurd boasts and vauntings and is not willing to do it justice and place it where it belongs as a useful member of society at any time. So, today, I would say to you that electrolysis is a useful adjuvant in treating urethral stricture. It will not cure all strictures of the urethra. Very many strictures it will not relieve in any way, but, on the other hand, there are certain conditions and certain forms of urethral engorgements in which it is, par excellence, the thing to use.

I do not believe in any specific. I do not believe that there is any one specific that will always cure a certain disease. We, of this enlightened age, know better than to assume or consider such a fallacy. When one tells you that he has something wonderful to always cure one condition, you will know that either he is a knave or else he has so little absolute accuracy that he does'nt know a diseased

condition when he sees it. There is, at the present day, no certainty in any curative agent or measure used. I mean absolute certainty. This is easily demonstrated by the constant change from year to year in every line of treatment.

Urethral stricture comes under the same line of thought. There is no one method but several methods which must be ever at the command of the surgeon who would do good work in urethral stricture. In all cases he must individualize each stricture brought to his notice and adopt the suitable line of treatment for that individual case. We believe the only real successful way to arrive at a correct opinion upon any new theory or method of treatment of any and all diseased conditions is to thoroughly, honestly, and carefully test its merits in our own practice, being very careful to follow out every detail as well as selecting proper cases for the trial. After such a trial, if sufficient number of cases are seen, and also a thorough following of the technique is observed, we can easily judge for ourselves of the success or non-success of such treatment. It is especially true that in treating urethral diseases we must remember that there are so very many outside influences which are constantly supervening and so much to change the character of the success, much more so than in ordinary diseases of the body. The moral effects, the method of discretion and indiscretion in diet, abuse of alcohol and tobacco, as well as peculiar personal idiosyncrasies,— all these, I say, must be considered in estimating the result or non-result of any treatment of the urethra.

The general treatment of urethral strictures has been considered to consist of one of several operations, viz.: internal urethrotomy, external urethrotomy, divulsion and dilatation. There have been two methods of internal urethrotomy,— one, the maisonneuve type, where the cutting has been done from before backward, and the other the Otis type, from behind forward. Of course, all these operations have for their object the enlarging of the urethral canal in order that there may be a free exit for the urine, for the work of urination is done by the bladder, and the urethra is simply a canal for the passage of the urine, and it is simply necessary to keep that canal in such a condition that the bladder can empty itself by a reasonable muscular effort.

It is always a difficult matter to know how early the formation of a stricture begins its development after a case of gonorrhœa appears. Some authorities on genito-urinary diseases claim that any gonorrhœal discharges which continue under proper treatment over three months must of necessity be then due to some encroachment of thickened tissue upon the lumen of the urethra. Others, equally high in authority, claim that no such excess of tissue formation can or is liable to form previous to six months and even in most cases beyond this limit. It is, however, good general practice to presume, if a case

presents itself at the end of three months' duration with a leaky urethra or the morning military drop or a gluing of the meatus, with more or less of a thin discharge, coupled or not with any variation in the character of the stream of urine, and in addition, in case the patient has had good treatment and had good habits, it is, I say, fair to presume that there should at least be an examination with the expectation of finding a stricture of some kind and quality.

Before using electrolysis on the urethra, perfect aseptic conditions should be observed as well as if more serious operations were to be performed, and, in fact, more care should be exercised when operating upon the urethra than upon any part of the body.

The urethra should first be washed out by some antiseptic solution. The electrodes should be made thoroughly aseptic.

The urethral electrode should always be made the negative pole, while the positive pole may be held in hand, or by preference, placed on thigh, abdomen, or sacrum.

Electrolysis should never be used upon an inflamed urethra. The currents should be galvanic or continuous, and usually only from three to eight milliamperes, never exceeding ten milliamperes.

If the foregoing conditions are carried out, it would, in our opinion, be impossible to meet with accident in this treatment of stricture.

Among the early advocates of electrolysis in urethral stricture may be mentioned such men as Malley and Trippier, of France, afterward by Alhaus of Germany, and later, Dr. J. A. Fort, of Paris, while in this country the names of Newman, of New York, Frank, of Pennsylvania, and Butler, of Buffalo, stand preëminent.

While there are many strong advocates of electrolysis in treating certain forms of urethral stricture, there are also those in high authority on the subject who equally condemn it. Among those adverse to the treatment by electrolysis are the following: In Robert W. Taylor's work on venereal diseases published in 1895, speaking of electrolysis and giving it only about one quarter of a page, he says: "This method of treating stricture need only be mentioned to be condemned. Its consideration is not worth the time and space it would require." He further says: "The aim of this treatment is to decompose the newly formed morbid tissue and to produce its absorption. Now, electrolysis has not an electro-affinity for the stricture tissue, leaving the mucous membrane unaffected, but on the contrary, acts upon this membrane and destroys it, and whenever the mucous membrane lining a stricture is destroyed there is a grave probability that the urethra will be obliterated." He also says: "It is probable in many cases in which some surgeons have claimed beneficial results from electrolysis that this agent did not exert its peculiar decomposing power, but simply acted as a stimulant, which may have, aided by other measures, tended to cause the absorption of some mild soft stricture."

In Morrow's work on genito-urinary disease, he says: "I have reviewed the entire literature of this subject, including the records of the work of Malley and Trippier, Newman and Le Fort, and have no hesitation in saying that the evidence adduced in favor of the method is altogether insufficient to warrant its general adoption, and does not justify even a belief in its usefulness in the average case. As to the claim that urethral stricture is radically cured by this method, it seems to me, in the light of the investigation of Keyes, Tilden Brown and others, simply preposterous. F. Swinford Edwards and Bruce Clark have been the most prominent British advocates of this method, but have failed to convince their colleagues on either side of the water of its efficacy."

In Carleton's little work on genito-urinary diseases, published in 1895, he simply mentions electrolysis as being useful and succeeding in many cases of resilient stricture, thus doing away with the more formidable operation of external urethrotomy. He leaves the subject with this simple statement without further comment.

In Hare's fourth volume of Practical Therapeutics, published in 1897, Thomas Belfield, under an article on stricture, says of electrolysis: "'The effect of a negative current of eight or ten milliamperes for ten minutes at intervals of three or four days has found some advocates; after much experience the writer considers this method much inferior to dilatation except in cases of almost impermeable stricture, in which it has repeatedly rendered him valuable service."

You see while some of these authorities utterly cast it aside as useless, others, while not advising, still see that it may be useful sometimes.

Where, then, is electrolysis useful in urethral stricture, and when?

1. I consider it especially useful in nervous, sensitive men who can bear no pain, easily excited, where sounds would be almost unbearable to them and could not easily succeed. They bear the electrode without flinching. Several applications in these cases render the urethra less sensitive and so much more tolerable that, if necessary, the sounds can then be used to complete dilatation.

2. In all soft strictures at any part of the canal the electrolysis will readily control without loss of blood or any pain of any moment.

3. It is especially useful and desirable of a thorough trial in strictures at or near the peno-scrotal junction, because at this point the greatest danger exists in all cutting operations because of the liability of hemorrhage.

The two principal methods used at the present time are those proposed by Newman and Fort.

Newman's method is the one most commonly used, where the stricture is treated by electrolysis, using a set of electrodes of varying sizes.

These electrodes consist of the egg-shaped, the acorn-shaped, the

tunnelled electrode and the combined electrode and catheter. The acorn electrodes are straight and intended for use in the first five inches of the urethra; the tunnelled electrode is for use in a tight and tortuous stricture over a filiform guide; while the combined electrode is for very tight strictures complicated with retention of urine as well as for bladder washing.

These instruments were invented by Newman and are extensively used by surgeons.

The electrodes advised and constructed by Dr. Fort are entirely different from Dr. Newman's. About one inch from the tip, on the concaved surface, protrudes a wedge-shaped piece of platinum. The size of the electrode at point of the platinum measures 26 F. The method pursued by the Fort advocates is to pass the electrode down to the stricture and turn on the current, and then as soon as the electrode passes through the stricture, turn off the current and remove the electrode, afterward passing in sounds to complete the dilatation. The sound is to be passed every week for three or four weeks afterward.

You will see that, by the Fort method, linear electrolysis is performed and the patient's cure finished by after dilatation with the sounds, while Newman's method absorbs the stricture without subsequent sound dilatation.

After having carefully measured the position and size of the stricture, which should be accomplished with the bulbous sounds or else Otis' methrameter, an electrode, one or two sizes larger than the stricture lumen (the negative pole being used), should be carried down to and against the narrowing, the positive pole being placed on thigh, back, or in the hand, then a current of from three to six milliamperes is turned on, when, usually in about one-half to three minutes, the negative electrode gradually passes over the stricture. The current is then turned off and the electrode removed. The treatment should be repeated about every six days, but the space of waiting should be governed by the condition of the urethra after each treatment as to irritation, etc.

There are many physicians, at present, who are using electrolysis in urethral stricture and claim for it much success in nearly all urethral strictures. Just how far this treatment willl be used in the future will, of course, depend upon the results accomplished. It needs a long time and many cases carefully managed to test its merits. I commend it to you for a thorough trial, feeling confident that, if thorough technique is carried out, you will be more than pleased at the result.

SPERMATO-CYSTIC DISEASE.

BY JAMES KRAUSS, M. D., BOSTON, MASS.

The seminal vesicles are to a great extent a dark country to the physician. The eye can see by means of the urethroscope only the mouth of the ejaculatory ducts. The finger can feel by way of the rectum only the lower portion of the vesicles, even when the bladder is full. In order to get at the whole vesicle we must strip the rectal wall off the perineum, or we must wait for the post-mortem table to tell us the full tale. Yet it is desirable that the diseases of the seminal vesicles should be more generally known, for the reason that such diseases do exist, that they cause great suffering, that they frequently cause sterility, and that persons suffering from these diseases should be cured.

Like every other organ in the body, the seminal vesicles may become inflamed, and the most common cause for acute vesiculitis or spermatocystitis is gonorrhœa. When the gonococcus has invaded the posterior urethra and we have an active posterior urethritis, it is only a question of time before the coccus enters the mouth of the ejaculatory duct or ducts and in its progress causes an acute inflammation of the vesicles. It is due to this progressive character of gonorrhœa that acute vesiculitis is often seen in connection with epididymitis. In such a condition the finger feels in the rectum above the prostate gland in an upward and outward direction a hot, tender, somewhat fluctuating mass of the size of the thumb. If as the result of posterior urethritis the prostate is affected, and we have acute prostatitis, we may not be able to palpate the seminal vesicles till after the prostatic inflammation has been subdued, when, generally, the acute attack of the vesicles will also have subsided into a subacute or chronic form. This explains why an acute vesiculitis is so rarely met with even if we are on our guard and look for its presence. But that it occasionally is unmistakably seen, is proved by the following case.

J. P. L., a boy of eighteen, contracted gonorrhœa and came to me eight days after the discharge had begun with a beginning epididymitis. He asked me to relieve him not so much of his gonorrhœa as of a sharp, excruciating pain in the rectum which he experienced whenever his penis became erect, and this, to his distress, was a frequent occurrence. Rectal palpation disclosed a flat, normal prostate, but above the prostate the right vesicle was very much enlarged, fluctuating, and tender, so that the least touch made him sick to his stomach, and gave him the sharp stabbing pain that he had experienced when his penis grew erect. The left vesicle was tender and large, but to a less extent. I ordered that the patient go to bed

immediately and apply cold cloths to his perineum. I prescribed bryonia, the next day mercury, and prepared myself for opening the abscess, for as such I took the mass in the rectum. The next morning he told me that he was discharging pus more than ever from his urethra, but that his pain was gone, and he had had no erections since midnight. On introducing my finger into the rectum I found that the tumor was gone. Though still sensitive to palpation, yet the vesicle had lost its tenderness to a great degree, and the sudden increased discharge through the urethra indicated that the abscess had burst and the pus had fortunately found its way along the ejaculatory ducts into the urethra, from there partially into the urinary bladder and, by overcoming the compressor, partially into the anterior urethra and out through the meatus urinarius.

I said this was a fortunate occurrence, for the abscess might have broken in the direction of the rectum, the perineum, the bladder, or even the peritoneal cavity, and the subsequent fistula might have proved an object for a formidable operation.

In consequence of acute spermatocystitis, the ejaculatory duct may become, and often does become, narrowed and occasionally wholly occluded. As the testicles continue to produce semen and the seminal vesicles do not cease to furnish their own secretions, the necessity arises for the seminal bladders to empty themselves, but when the vesicles contract and send their contents onward, these meet with the obstacle in the ejaculatory duct and severe pain results as an expression of the futile efforts on the part of the seminal vesicles to discharge their contents. We then have, what Reliquet has so aptly described, spermatic colic, a condition analogous to renal and hepatic colic.

The occlusion of the duct may lead further to either one of two conditions. The contents of the vesicles may harden. The spermatozoa, the mucus, and the epithelium become inspissated and form sympexious concretions. Or, the fluid contents may continue to be increased until the seminal vesicle forms a cystic swelling, which, under certain conditions, may assume an unusual size and call for the acutest differential diagnosis. Jacobson, of London, reports a case of a cyst from which he drew ten pints of fluid.

But the most frequent result of acute spermatocystitis and the consequent narrowing of the ejaculatory ducts is chronic vesiculitis. Men come to us for treatment more often for this condition of the seminal vesicles than for any other one disease of these organs. At the present time I have two such cases under treatment. Pain and fulness in the perineum go together or alternate with painful erections, micturition, and defecation, and when there is an exacerbation there usually follows a recurring epididymitis.

In all these conditions depending upon a narrowing, if not an occlusion, of the ejaculatory ducts, the chief problem is to overcome this narrowing. A stricture of the urethra, of the larynx, or of the

œsophagus can be dilated or divided, but what can be done for a stricture of the ejaculatory ducts? The duct is, so to say, buried from sight. Up to this moment no instrument has been introduced into the duct through the natural road. I have made some experiments on the subject, but so far I do not see how the object of instrumentation can be attained without undertaking a severe cutting operation.

Still I believe there is a possibility of success in the future, and experiments in this direction should be encouraged.

There remains for our consideration a process, first suggested by Fuller, of New York, and called by him milking of the vesicles, very likely because the method resembles so much the milking of the udders of a cow. Yet the idea is not so much of pulling as of pressing the muco-purulent contents of the vesicle through the narrowed duct. At once certain objections rise in the mind of the anatomist as well as of the surgeon. How will you reach the vesicles when your forefinger is not long? And how do you propose to milk an organ of which, at the very best, you can reach and cover only the lower half? And how should you expect to be able to force the contents into the ejaculatory duct when the seminal vesicles have not the structure and arrangement of racemose glands, but are made up of diverticula or tubes that have blind ends? Yet with all these apparent objections cropping up at the outset of this procedure the fact remains that the vesicles can be milked and that, if properly done, our patients are greatly benefited by it.

In my practice I direct the patient to come for treatment with a full bladder. I have him bend his body forward at right angles, stand with his knees straight, and support himself with his hands on a chair. Then, having oiled the forefinger of my right hand, I introduce it into the rectum, pushing well beyond the posterior margin of the prostate.

If I can do this easily and can detect on each side the body of the vesicle, I place the fist of my left hand over the pubes for the purpose of counter-pressure and proceed to milk the vesicles one after the other. But if it happens, as it almost always does, especially in the beginning of the treatment, that owing to the tenderness of the vesicles and the disagreeable sensation incidental to the rectal manipulation the perineal muscles rebel and resist the effort, it becomes necessary to overcome the resistance of the perineum. There is nothing that will do this better than firm, well-directed pressure against the perineum. While the forefinger is in the rectum the remaining fingers close into a fist and press against the perineum. If this is not sufficient to overcome the resistance, I place my right foot on a low chair so as to bring my bent knee on a level with my elbow, and then I push the knee against the elbow to increase the force of pressure exerted by the fist against the perineum, and the most rigid perineum must relax and allow the finger to milk the vesicles. After milking

the vesicles a few times, the vesicular tenderness decreases as well as the perineal resistance.

The milking, finally, consists of making firm pressure with the tip of the forefinger in the rectum on the body of the vesicle and drawing the finger firmly forward and downward against the pressure of the fist from the pubes. This process is repeated several times on each vesicle once or twice a week, but never oftener for fear of causing acute symptoms. At the first few sittings the contents of the vesicles may not pass through the prostatic sinus, but later, after each manipulation, the patient expresses himself that something is coming and we obtain the seminal fluid either direct or with the urine.

Then, by occular and microscopic inspection, we may ascertain whether, now that the condition of aspermia has been proved to be dependent upon the narrowing of the ejaculatory ducts, the sperm fluid reveals the presence of oligospermia, oligozoöspermia, azoöspermia, hematospermia, or, if you permit me to coin a term for a condition which has not yet been christened, leucocytospermia.

Hematospermia, that is, bloody semen, in a non-gonorrhœal subject always raises the suspicion of tuberculosis and usually the tubercle bacilli will be found in the semen and perhaps in the urine. Through the rectum we feel the tubercular nodules.

Tuberculosis of the seminal vesicles is in the great majority of the cases secondary to tuberculosis of the prostate gland and the bladder, hence its treatment must be subordinated to the treatment of these last conditions. But where vesicular tuberculosis is primary we must take into consideration the question of immediate and complete extirpation.

I have thus depicted the essential diseases of the seminal vesicles, and if I content myself with a mere outline of the subject and pass by the consideration of traumatic and cancerous diseases, it is only because in the short time at my disposal it is impossible to give more than an outline. But I hope I have proved that the subject deserves our careful attention.

SKIN LESIONS IN TERTIARY SYPHILIS.

BY A. H. POWERS, M. D.

In addressing a company of men and women engaged in the active practice of medicine it hardly need be said that skin lesions in tertiary syphilis are not rare. However, since they are so frequently mistaken and accordingly maltreated, a short study of these cases may prove of profit. It should not be necessary to say that the line between the secondary and tertiary lesions is often a line difficult to trace, and that lesions do at times present some of the characteristics of each class. And first as to the time when these appear.

Perhaps it is this broad latitude which confuses so many, but it is a fact that these lesions of the skin may appear at any time from twenty months to twenty years after infection and probably occasionally an earlier or later involvement is seen. The time when these tertiary lesions are most frequent is from three to ten years after the primary sore. These lesions are not found in all cases of syphilis, but only in a certain percentage ; and yet they are very important and at times dangerous lesions. It is estimated that only ten per cent. of syphilitic cases present tertiary lesions in any part of the body, and of this number only a percentage of the lesions are found in the skin. Fournier's personal statistics of about 3,500 cases give a percentage of twenty-two plus as located in the skin. Since they occur so long after the infection, the patient has often forgotten the earlier symptoms, and it is not rare to find well-marked tertiary lesions in patients who can give no history of previous syphilitic trouble. How much the previous treatment or lack of treatment has to do with the frequency and severity of these lesions is a question still *sub judici*, but the general feeling is that they can be avoided or lessened by skilled care at an earlier period.

The types of these tertiary lesions are that of the tubercle and the gumma, which perhaps, when in the skin, may well be recognized as a large tubercle.

The tubercular syphilide may be found on any part of the body, but has a predilection for the face, nape, palms, and trunk. On the face they not unfrequently form the corona veneris of the forehead. The lesions are very often in a circle or arc of a circle, and they progress peripherically, healing from the centre. The number of lesions on the body at one time is usually small, and in size they vary from a pin's head to a pea.

The raw ham color is not often present, and they are always hard to the touch in the earlier stages before they have broken down. There may be a simple scaling or the process may go on to ulceration. Following ulceration scars appear, and these scars are not unfrequently

diagnostic. I will refer to these scars later in this article. Like most syphilitic lesions these are usually painless. It is usually held that these lesions are not infectious, or if early in the course of the disease, slightly so.

The other form of tertiary lesion is the gumma, which is practically a large tubercle. These vary in size from a pea to a growth as large as a hen's egg. These are frequently situated in the subcutaneous tissue rather than in the skin itself. The scalp and legs are the locations which are most frequently invaded. Usually there are only a few lesions present at one time, and not rarely a solitary point is the only symptom recognizable. The duration of a single lesion is variable, but usually they remain for some time, and months may pass between the discovery of a small nodule in or under the skin and the complete healing with its depressed parchment-like scar. With the gumma before ulceration there is rarely pain, but with the ulceration there is often septic infection and a laying bare of the deeper tissues. From the long duration of the lesion it is well-nigh impossible to avoid septic infection if the gumma ulcerates, but the system is seldom involved in any septic process, it usually remaining local.

Some diagnostic points have already been noted, but we can do no better than study for a few minutes the points of differentiation. And the first point is the location. Ulcers on the upper half of the leg or about the knee are always suspicious. So also are lesions in the palm of the hand. The circular or crescentic outline of the group of these lesions is quite noticeable. Often it may prove a diagnostic aid. The typical raw ham color of the earlier lesions is not so often seen in the later ones. The coloring about the ulcers is often a deep red, and this color remains for a time after healing has taken place. The lack of pain is characteristic, but as already said, after septic infection there may be much pain, and this pain I have known to mislead and confuse the practitioner. Again, since there is so little or no pain at first we may fail of the opportunity to see the lesion when diagnosis is easy, since no one is consulted.

Induration is always present early and often throughout the duration of the lesion, but it is often slight about a large gumma, after it has broken down. A syphilitic history is always in aid if it can be obtained, but to exclude syphilis for lack of a clear history is manifestly unwise. As the lesions are painless in many instances, and since years may have passed since any lesion has been present, we need not wonder or call our patient untruthful if we fail to elicit the history which must have been enacted. Rather let us confirm our suspicions by any scant aid we may win from the patient. I will briefly sketch two cases recently under my observation.

Mrs. A. W., age thirty-five, married six years, has one child, a boy of four. Husband living, strong. No history of miscarriage or other skin lesions. Has been under treatment for six months with no

improvement, and pain is increasing. Presents on the right leg just below the knee on the anterior aspect two ulcers, one the size of a copper cent and the other pea-sized. The smaller is the more inflamed. There are two or three scars near the lesions which the patient says were just like the present lesion. The general health has been impaired, and sleep is poor from the pain of the lesions. Has lost ten pounds in weight the past six months. The bones of the nose are sensitive, the nose seems swollen, and the nostrils are filled with greenish bloody crusts. There is no pain in the nose or any other symptoms noted. Under antisyphilitic treatment the pain was speedily relieved, the ulcers healed promptly, and the patient has recovered her normal weight.

Miss L. F., age twenty-three. On the right arm, outer aspect, three inches above the elbow, there is situated an ulcer as large as a silver dollar, with distinct edges and extending to the deep fascia. On the lower anterior border of the ulcer is an area of thin scar tissue which the patient says was the site where the lesion began. It has lasted a year and has never healed. Is most indurated on the upper border. Has had similar lesions on the left thigh just above the knee, leaving thin, depressed scars. Gives a history of sore throat and headache two years ago for which she entered the hospital, but was not told the cause nor did she gain relief. Remembers a crack in her lip four years ago which as she remembers healed quite promptly. Has been under the care of her present physician for a month and improvement has not been noted, hence she was brought for diagnosis and treatment.

These are only sample cases which are often seen, and a score could be added to the list of those seen in the past six months. On paper and as I have read them they may seem easy to diagnose, but no other disease is so often sent to me for diagnosis, and that by able members of our profession. Hence I must in this connection call the attention of the profession to the prevalence of this disease, and urge that never should syphilis be forgotten in any case of chronic skin trouble. That syphilis is on the increase may well be believed, though naturally statistics are not at hand to prove or disprove the truth of the impression. As in other tertiary lesions the iodides must have the first place in treatment. Locally if ulceration has occurred, antiseptics are useful. Here I must confess a fondness for the use of some mercurial preparation, though filling the ulcer with iodoform cerate is usually very beneficial. The odor, however, is a marked objection, especially with women and in private practice. Many other remedies may often prove useful, but I have already trespassed too long on your patience and I will not now discuss them.

DISORDERS OF DIGESTION AS A CAUSE OF ECZEMA.

BY JOHN L. COFFIN, M. D., BOSTON, MASS.

The importance of disorders of digestion as a cause of eczema is a subject concerning which there has been much difference of opinion; some maintaining that as a cause of this disease their effect was slight; that digestive disturbances occurred not much oftener in eczematous subjects than in non-eczematous; and that when they did occur they were more coincidental than causal. Others again make claim that in many cases much responsibility may be laid upon the intestinal tract.

With the object in view of seeing to which side of this mooted question my personal experience in the treatment of this class of cases tended, I have endeavored to make such critical examination of the cases of adult eczema occurring in my private practice, within the past two years, as notes taken somewhat hastily, and in some cases meagrely, would allow, and to present to you the results of such examination for your discussion and criticism.

Of the fifty-four cases of eczema in the adult, from which I had sufficient notes to draw any deductions, I found symptoms referable to the digestive tract in forty-one, or 75.9 per cent., cases. Fifty per cent. showed indigestion, either gastric or intestinal; and thirty-seven per cent. were the unhappy victims of constipation, more or less chronic.

Such a large percentage as the above would certainly indicate something more than a coincidence, and, coupled with the fact that medication directed to the removal of these digestive symptoms was almost universally accompanied by the cure or amelioration of the eczema, would certainly place them among the most common causes of this distressing complaint. Examination of the symptoms shows also great consensus; the following being present in nearly all the cases: eructations after eating, sometimes immediately, sometimes one or two hours after a meal; distress after eating, a sensation of fulness and distention, entirely out of proportion to the amount ingested; sleepiness and dulness after eating; water brash, bitter taste on awaking in the morning; intestinal flatulence; constipation; a sensation of fulness or heaviness and discomfort almost amounting to pain in the right side, in the region of the liver. These subjective symptoms were frequently accompanied by a broad, flat, rounded, slimy tongue, in some cases marked by the teeth. The urine in those cases when it was examined, was rather deficient in quantity, of high specific gravity and strongly acid. In a few of the cases there were concomitant subjective symptoms, of dull heavy headache, sleeplessness, flushing of the face, and dizziness.

Investigation into the dietary habits of these patients showed errors both as to kinds of food and manner of eating and drinking. Twenty-four per cent. used sugar and sugar-containing foods to excess, and twenty-six per cent. lived largely on a meat diet. In nearly all of the cases the amount of water drank was comparatively slight. The following case may be cited as a fairly representative type of this class:

Mr. Blank, age 37, short, dark complexion, not very stout. Business, manufacturer. Has erythematous eczema of face, anterior surface of neck and upper part of chest, in the last location being rather papular in character. This condition, of ten months' duration, presents on fronts of both wrists thickened, red, scaly patches of squamous eczema of several years' duration. Digestion generally poor. Has "sour stomach" and nausea. Bowels regular. Occasionally rheumatic pains; urinates frequently, sometimes with slight burning; tongue slightly coated white; eats meat, generally beef, three times a day; very fond of sweets; smokes from five to seven cigars and takes a little whiskey daily. Does not drink much water and has comparatively little exercise.

This train of symptoms, indicative of what Bulkley aptly terms "defective disassimilation," goes very largely to make up what we are daily learning to recognize as the so-called "gouty state," a condition in the production of which functional derangement of the liver is supposed to take a not inactive part. But whence comes this functional derangement of the liver?

More than ten years ago it was shown that functional derangement of the liver, characterized by furred tongue, loss of appetite, sallowness of the skin, etc., was caused by impeded circulation in the liver, due to, or rather secondary to, irritative conditions of the gastric mucosa; and at the same time the idea was advanced that certain poisons were generated in the intestinal tract upon which the bile acted as an antiseptic.*

Since that time it has become fact that many poisons are generated in the stomach and intestines, notably lactic, acetic, and oxalic acid, acetones and various micro-organisms which depend largely upon the liver for their elimination or destruction; and if this burden be too great for this long-suffering organ to accomplish, or the burden be too continuously borne, the liver itself must sacrifice some part of its integrity. On this point I cannot refrain from quoting from Mons. Boix's interesting work, entitled "The Liver of Dyspeptics." Referring to the circulation of these poisons of intestinal origin in the liver, he says: "Once the poison is in the presence of the hepatic cells, one of three things may happen: either the functioning of these cells will be normal and adequate to destroy or transform the poison, the

* "Liver of Dyspeptics," by Dr. Emile Boix, page 35.

whole evil being averted in the afferent portal vessels; or their functioning will be inadequate; and then if the amount of the poison be very great, the cells will succumb. If the amount is not so large, insufficient to immediately alter the cells, they will be able to transform, a portion of the poison, but the remaining portion may pursue two paths: first, that of the intra-lobular veins, and there will be a slow intoxication of the whole economy; second, that of the biliary canalicule, which will convey the poison outwardly, but not without injury to themselves."

Auto-intoxication then, this "slow intoxication of the whole system" above alluded to, which results from the production of poisons within the economy, which in their turn are due to improper kinds and quantity of food and general disobedience to all hygienic laws pertaining to eating and drinking, accounts in very large degree for the occurrence of eczema in the adult.

All agree that any irritation applied to the exterior of the skin may cause eczema; it is equally sensible to believe that the circulation through its interior of a medicine containing irritative toxic principles will cause equally severe results. This it accomplishes in two ways: by its intrinsic irritation from within, and by so impairing the nutrition of the skin as to make it much less resistant to injury from without.

REPORT OF COMMITTEE ON LEGISLATION IN VENEREAL DISEASES.

Your committee, having carefully read all of the records upon this subject within their reach, have arrived at the following conclusions:

1. That legislation looking to the inspection and registration of prostitutes is undoubtedly efficacious in some garrison towns and communities living under military discipline.
2. That the efficiency of such legislation is extremely doubtful in a mixed community.
3. That the greatest danger to our people does not lie in the classes which would be reached by such legislation.
4. That the sentiment of the profession and public of this country is undoubtedly opposed to legislative action of this nature.

The committee would therefore offer the following suggestions:

That, while recognizing the terrible seriousness of the evil, we believe that the present most practicable method of controlling it lies in the education of the people, and that it is the duty of the members of the profession to impress upon their clients that venereal disease, of any nature, is a public calamity.

The Committee would also suggest that education along this line should be offered during the youth of our clients, and that no patient capable of understanding the subject, is either too old or too young to receive benefit from an impartial statement of the facts.

WINFIELD SMITH, M. D., *Chairman.*

REPORT OF COMMITTEE ON MATERIA MEDICA.

FREDERICK A. DAVIS, M. D., *Chairman.*

I. A Critical Analysis of Hughes' Cyclopædia. Conrad Wesselhoeft, M. D. Discussion: J. P. Sutherland, M. D.

II. A Glance at the Tox-albumins. J. Heber Smith, M. D. Discussion: F. B. Percy, M. D.

III. Local Application of Nitrate of Silver in Herpes.
John P. Rand, M. D.

THE PRACTICAL IMPORTANCE OF HUGHES' CYCLOPÆDIA OF DRUG PATHOGENESY AND THE REPERTORY THERETO.

BY CONRAD WESSELHOEFT, M. D., BOSTON, MASS.

Mr. President and Members of the Society:

The announcement was inadvertent that this was to be a critical analysis of Hughes' Cyclopædia; my purpose is to speak of the great value and merit of the work, especially in its relation to the repertory which has just been announced.

What we desire to get is practical knowledge of the materia medica, that is, of drugs whose properties are known with relation to their use in disease. We will take it for granted that such drugs cure the sick, and we will not discuss that question at all except to say that as long as the world stands it has been believed that when one is ill he must swallow something to get well. That was in the early days of medical history, but the confidence in medicine has not been shaken yet, on the contrary, it has increased, especially since Hahnemann's time it has become axiomatic that the only way to know anything about the substances to be taken into the system in disease, is to test them first upon the healthy organism. Internal medication is still striving toward perfection as a science, and let me here say a few words concerning our present sources of information on the subject of practical therapeutics.

What we have heard here today in regard to specialties, and in the reports from special bureaus, would seem to show that the mechanical treatment of disease is in the ascendency, but it must not be forgotten that treatment of disease by internal medication is still made the subject of study and is progressing under the care of the most

eminent medical minds of the age, and that the general practitioner is not yet extinct.

Among the sources of information in regard to methods of using materia medica, are text books on pathology and therapeutics. These teach us little more than routine prescribing, by telling us what medicines are good for certain diseases; they specify as well as possible a certain number of such medicines, but they cannot specify indications for remedies as such indications actually occur in practice; for such indications can only be found in a complete pathogenesy like that of Hughes', with the aid of a good repertory. (Books of this kind are those of Baehr, Kafka, Hartmann, Goodno.)

There is another class of text books, partly digests, partly compendia, of materia medica proper (Farrington, Cowperthwaite); these are all excellent in their way, also serving the purpose for which they were intended, provided always they state the best ideas of other men, yet they are not strictly speaking, sources of original information, but rather the works of authors than of authorities, and hence not exactly fountain heads of the true knowledge of materia medica.

What we need first, last and all the time, are books containing the records of original research, that is of provings — the only reliable and safe basis of therapeutics, whether in specialties or general practice. Now Hughes' *Cyclopœdia of Drug Pathogenesy* is such a work. It is not intended to replace, but only to supplement Hahnemann's Materia Medica Pura. A great deal has been added to the materia medica since Hahnemann's time; material has been collecting and has been stored away in periodical literature awaiting the time when it could be put to practical use. Dr. Hughes has done this in a scholarly and conscientious manner, without any other reward than the consciousness of having faithfully completed the task entrusted to him. By thus supplementing Hahnemann's work he has improved it by corroborating its contents, or, at least, affording us the opportunity of doing so.

Neither is it intended to replace Allen's great work. Speaking of these last two, a slight comparison is not out of place here to show where they differ from the work of Dr. Hughes. The latter contains original and unchanged proving records, while Hahnemann's Materia Medica Pura, and Allen's Encyclopedia have their matter arranged anatomically, thereby already impairing the originality and purity of the material. Such an arrangement undoubtedly facilitates the finding of symptoms, but at the same time it distorts them by tearing them out of the context. Also when you take these very remedies arranged anatomically and compare them with the original provings, you will be surprised to see how they have been changed in their arrangement into separate anatomical groups.

The value of Hughes' book is enhanced on account of its making a critical choice in the selection of provings — a method which Hahne-

mann and Allen do not adopt in the same degree. If you will read the introduction to the Cyclopædia you will learn from it that Hahnemann has used a great many provings whose authors and whose methods were uncertain, and that he included many clinical symptoms which were not the result of provings, but which were a transcript of cured cases the symptoms of which were supposed to belong to the medicine to which the cure was attributed. Useful as this may be, it is not, strictly speaking, "pure materia medica" in Hahnemann's own sense. These provings are all contained in the Cyclopædia, but may easily be distinguished by their smaller type. Then there are the most reliable provings, whose authors and methods are known, while less reliable provings, or those made with excessively high attenuations, are omitted. Such information is not lost but may be found in Allen's Encyclopedia. In Hughes' work on the other hand we find that reduced to normal relations again which was separated in Hahnemann's and Allen's works.

The Cyclopædia was prepared partly under the auspices of the British Homeopathic Society, and partly under those of the American Institute of Homeopathy, the beginning of the work dating from 1882. There will be time to say only a few words of how to study it. Take up almost any of the principal remedies there named, such as Aconite, Belladonna, etc., and read it through. If the anatomical schema should fatigue you, this narrative style would fascinate you like a story, and you would not care to lay it down until you had finished it. You would then already have retained much of it in your mind, partly because you observe a series of necessary consequences, and partly also because there is noticeable a repetition of effects. If you will then close the book and write down what you remember, you will find that materia medica is more interesting and less difficult than you would suppose from the reputation which it had gained entirely from poor methods of studying either the schematic arrangements or less reliable sources. Follow this plan with one or two remedies every week or every day if you have time, and you will not find it as difficult to acquire a good share of the materia medica as it would be to learn anatomy or pathology. You will soon become aware that the test of a good proving is the conformity and agreement between the statements of the various provers; if their results are not as reliable as desired, each will tell a somewhat different story, or a very tedious rambling endless one, such as nervous invalids tell us. Now, if you have taken note of the most characteristic but congruent symptoms, then proceed at once to make your own anatomical arrangement of them. Some years ago I read an article here which I called "Every man his own Bookmaker." I was not sure at that time as to whether I had said anything to the point; but I have become more and more convinced that it is best for each to make his own repertory. I say it for the reason that each one can make the best use of his own work

which he understands. If I should make such an anatomical arrangement or repertory, it would be of less use to others than as if they had made it themselves out of familiar material. But such a repertory for private office use, must of necessity be small, still it would have the inestimable advantage of having introduced the author to, and familiarized him with the larger and complete Repertory of the Cyclopædia now being issued. Without such preparatory work the new repertory to the Cyclopædia would be difficult to use.

The arrangement of the new repertory is simple, but will require time and patience in its use. It is a complete reference to Hahnemann's Pure Materia Medica, to The Chronic Diseases, to the *Fragmenta de Viribus*, and lastly to the four volumes of the Cyclopædia itself. A desired symptom can readily be found in most, or even in all, of these works, by following the reference. But that means work, and on that account many may not care to use it much; for this same reason the Cyclopædia has not been respected as it should have been. Yet, if the general practitioner would prove his right to exist by the side of the mechanical specialist, he can do it no other way. Again, as long as the field of general therapeutics is but just beginning to be opened by better sources of original work and better books, constant mental application is a necessity; and, mainly, if we are convinced that medicine can best be given according to the law of similars, there is no other way to demonstrate it except through faithful application, study, and above all, by the cultivation of a certain degree of talent for the acquisition of such knowledge.

In times when every mother of a family had her "Domestic Physician," this work with its accompanying box was safely put away in some closet, and was supposed to contain all sorts of useful directions for any emergency that might arise. Perhaps this did not occur for a long time, until suddenly in the night someone was taken desperately ill. The book was wanted, but only found after much searching, because its hiding place had been forgotten; and when at length found and opened, where among the four hundred pages of wisdom was the thing to do mentioned? To save an anxious mother from such a dilemma, she was urged to wait for a time when everybody was well in the family, and then to read the book carefully and repeatedly, and also to scan it from time to time, in order to know what each chapter contained, and where subjects were to be found. Then, in an emergency, the book would be of great comfort and assistance. The same applies to the Cyclopædia and the repertory belonging to it. Let us all become acquainted with it before emergencies arise. There is a mine of wealth there, but no easier to get at than the gold in the Klondike region.

NITRATE OF SILVER AS A LOCAL APPLICATION IN THE TREATMENT OF HERPES.

BY J. P. RAND, M. D., WORCESTER, MASS.

My early experience in the treatment of herpes was not satisfactory. True, my patients all recovered, but it seemed as if they never would. The eruption would disappear all right in a week or two, but following that would remain a most persistent neuralgia almost if not quite as severe as during the eruptive stage. It was not the exception but the rule for severe neuralgia to continue for weeks in these cases, and sometimes it would be so bad as to require the use of opiates for relief.

One day when I was in practice at Monson a young man came into the office with a slight herpetic eruption upon the external ear. He promptly informed me that it was "erysipelas," to which he was occasionally subject, and that his former attendant, an old-school physician, was wont to apply something to it which turned the skin all black and cured the eruption right up.

I did not propose to be outdone by my predecessor, and knowing the popular use of iodine in the old school for erysipelas, applied a generous coat of the tincture to the maturing vesicles.

The next day he appeared and informed me my application had done no good and hence could not have been the same that Dr. S—— had applied. Though I still believed it was, my patient was not convinced, and so I looked about again for something in the "black art" which would serve as a placebo. The only thing I could think of was nitrate of silver, and this I applied simply to satisfy my patient.

The next day he reported at the office, when I found that every vesicle touched had begun to dry up and disappear. Three days later the man was well. I had never seen a case progress so satisfactorily before, and I resolved to give the remedy further trial. It is now over ten years since my attention was called to the use of the drug in this way, and since then I have applied it in all my cases. To be sure, I have varied the strength somewhat, sometimes using a solution of ten grains to the ounce, and at others applying the actual caustic, but in no case have I observed the persistent neuralgias which I had previously noted, and in only one patient to my knowledge has there been any necessity for subsequent treatment.

The patient was a delicate woman belonging to the family of another physician, which relation may have had some influence in the case.

My usual mode of application is to touch over each vesicle separately with the moistened point of a caustic pencil, taking especial care not to overlook the smaller vesicles just appearing in view. Sometimes I use a saturated solution of the drug and apply with a tiny swab made from a bit of absorbent cotton and a toothpick. At the expiration of ten days, if the vesicles have not begun to dry up, I repeat the application and every day I watch particularly for the appearance of any new ones. It is very seldom that a vesicle cauterized at the start will develop any further.

Of late I have abandoned the old-time remedy ranunculus bulbosa, from which I never saw any results, and administered in its stead the 3 x trituration of argentum nitricum.

For some years I supposed I had stumbled upon a unique if not an original method of treatment, but I found my mistake. In fact the man who thinks he has originated something new in any department of knowledge had better shut himself up with his delusion and never read if he wishes to keep it.

Erasmus Wilson in his work on cutaneous diseases, published in 1866, says :—

"Experiments have been made with ectrotic remedies, but their advantage has not been fully established. The best of these is a solution of nitrate of silver in nitric ether, which we have known to give considerable relief. It is a good application for all the local forms, particularly herpes præputialis. Another mode of using the nitrate of silver is to puncture the vesicles, and after absorbing the serum to touch the base with a point of the caustic. With the local forms this plan answers extremely well."

No other writer, so far as I know, makes any mention of this use for the nitrate of silver.

Taylor even in his magnificent work on skin diseases does not speak of it at all, nor have I noticed it in any other text-book. My own experience with the drug has of course been very limited, for it is only occasionally that the ordinary physician will meet such cases in practice. A few personal friends are trying it by my suggestion, and I hope at some future time they will report their experience to the profession.

I regret that I have no exact record of cases treated, for I am sure the method is worthy of a more extended trial.

In closing let me report from memory the brief history of a single case :

Patient, Mr. W——, age about twenty-two, occupation a baker, called at my office Friday, August 10, 1894. For several days he had been suffering from an herpetic eruption as large as a man's hand in the left groin extending on to the penis and corresponding half of the scrotum. In the centre of the patch the vesicles had fully matured, and some of them were already ruptured.

The eruption was so extended, and the application over the broken vesicles so painful, that I did not apply the caustic on the whole of it. As it was, the man became somewhat faint either from the procedure or excessive heat.

The next day the patient came again to my office, and the same evening I was called to see him at his house. Sunday, Monday, Tuesday, and the following Thursday he came to the office, after which time he received no further applications or medical treatment, and was able to return to his work on the following Monday. All told, he was under observation but seven days, and only lost ten days from his work.

The only internal remedies were argentum nitricum 3 x, with 3-grain tablets of acetanilid, to be taken as needed for the pain.

The case was as severe a one of the disease as I ever saw, and from my early experience I should have expected the neuralgic pains to have lasted for at least a month, but the patient assured me that they gave him no particular discomfort; at any rate he got along with only a week of medical attention.

DISCUSSION.

In a discussion of Dr. Rand's paper, Dr. H. L. Chase has observed distinct stinging in mouth and slight nausea by 3 x arg. nit. and has found this remedy useful in these conditions.

PROCEEDINGS

OF THE

FIFTY-EIGHTH ANNUAL MEETING

APRIL 13, 1898.

The fifty-eighth annual meeting of the Society was held at Steinert Hall, Wednesday, April 13, 1898.

The meeting was called to order at 10.25 A. M., by the President, Dr. Howard P. Bellows.

The minutes of the last meeting were read by the Secretary and approved.

The reports of the Treasurer and Auditor were presented and approved.

TREASURER'S REPORT.

Massachusetts Homeopathic Medical Society in account with Winslow B. French, M. D., Treasurer.

BOSTON, MASS., April 11, 1898.

CR.

Received from H. C. Clapp, treasurer	$1,738.47
" " yearly dues	998.34
" interest, Old Colony Trust Co.	14.11
Total receipts	$2,750.92

DR.

Expended for use of hall	$80.00
" " catering	177.75
" " salaries treasurer and secretary	100.00
" " contract pub. Med. Gaz.	200.00
" " postage, printing, stationery, engraving, etc.	154.89
Total expended	$712.64

Cash in treasury as follows:

Deposited in Savings Bank of East Weymouth	$500.00
" " " Weymouth	500.00
" " " Abington	500.00
" in Old Colony Trust Co.	526.28
Cash on hand not deposited	10.00
Total amount cash on hand to bal.	$2,038.28

Of which balance $1,000 is invested by vote of the Society, the interest only to be used for special purposes, leaving an actual working balance of $1,038.28.

The interest of money in the several savings banks is not payable for some weeks, and does not appear, for that reason, in this year's accounts.

Uncollected dues, $805.00.

Respectfully submitted,

WINSLOW B. FRENCH, *Treasurer.*

Approved: EDW. S. ALLEN, *Auditor.*

The Necrological Report was read by title and referred to the Publication Committee.

On motion the Secretary was instructed to cast the ballot for the following candidates, who were duly elected.

J. Miller Hinson, M. D., Boston.
N. H. Houghton, M. D., Boston.
Caroline Y. Wentworth, M. D., Newton Highlands.
Alvin Boyce, M. D., West Medway.
Frances M. Morris, M. D., Boston.
David W. Wells, M. D , Boston.
Frank E. Allard, M. D., Boston.
Sarah Sweet Windsor, M. D., Boston.
Edward E. Allen, M. D., Charlestown.

The President appointed Drs. Powers and Hopkins as tellers to receive and count the votes cast for officers to serve for the ensuing year.

Dr. H. L. Chase, Chairman of the Committee to prepare a suitable testimonial to Dr. Herbert C. Clapp, as an expression of the feelings of the Society for his long and faithful services as Treasurer, reported that the Committee had decided on the presentation of the accompanying gold watch. (Presented to the President.)

The President: Dr. Clapp, in many ways and at many times, both as individuals and as members of this Society, we have expressed our trust in you personally and professionally, and in

our frequent election of you to the position of Treasurer. We cannot wholly express to you, in any tangible form, our appreciation of you and your services, but we seek in this modest way and means to suggest to you hour by hour, and day by day, the continuous good wishes of this Society, and I have the honor acting under and in this spirit, of the members of the Massachusetts Homeopathic Medical Society, to present to you this watch with its inscription, as indicative of our feelings towards you.

Dr. Clapp: Mr. President and members of the Society. I had no idea this was to be a watch meeting. Since the last meeting I have had some suspicion that I was to be honored with some expression of the good will of the Society, but not until this moment did I realize the form and value it was to take, and I desire to express my heartfelt appreciation of this beautiful and valuable gift, the token of your esteem. I think we all prize the good will of our fellow citizens and I should like to go with the majority. But I desire to say that very much more than that of any other class in the community, I prize the good will of the brethren in the medical profession. I think that our profession is in closer touch than any other, and rightly so, for we have the same livelihood, the same tastes in many ways, the same bond of sympathy, the same failures, and thus we are the better able to appreciate each other much more than any other part of the community can feel to those around them. In my thanks to the brethren I do not mean to make any distinction, for here as elsewhere they are supposed to embrace the sisters.

Dr. N. Emmons Paine moved and it was carried that the courtesy of the floor be extended to Dr. A. J. Givens, of Stamford, Conn., who was in attendance upon the meeting of the Society.

Dr. Paine presented the following resolution:

Resolved, That a committee of three be appointed by the chair, to be known as the Fund Committee of the Massachusetts Homeopathic Medical Society, whose duty it shall be to recommend to the society, for its action from time to time, such uses of the principal or interest of the fund as they may deem most advantageous to the Society. The term of service of the members of the committee shall be three, two, and one years, respectively.

He also stated that the resolution referred to the surplus fund of one thousand dollars which had been set aside by the Society at a previous meeting as a permanent fund. At present there was no distinct arrangement as to its disposal. It was under the

care of the Executive Committee and the interest turned into the general fund of the Society. It seemed best that the oversight of the fund and the uses to which it should be appropriated should be entrusted to a permanent committee rather than to one in which the personelle was continually changing, and whose tenure of office was for a year only. There would be the better chance of maintaining a settled policy in such a committee. There were many plans to be determined upon, all having more or less claims to permanency. The interest might be added to the original fund and in time we would have quite an accumulated fund; or the interest of one or more years could be used to establish a prize in money, or a medal, or take some other form, to recognize some special meritorious work in professional lines; or by allowing an accumulation we might have a fund to aid those members of the profession who had been particularly unfortunate. These, of course, were only suggestions, but they were given to show the necessity of some permanent plan on which the fund should be managed.

After some desultory debate, and the decision that the motion was not contrary to the By-Laws, the resolution was unanimously adopted.

The President: I will appoint on that committee, Dr. N. Emmons Paine (3 years), Dr. I. T. Talbot (2 years), and Dr. H. C. Clapp (1 year).

REPORT OF THE COMMITTEE ON REVISION OF BY-LAWS.

The committee presented a number of verbal changes in the By-Laws, the subject matter of which had been presented at previous meetings, and on motion these changes were so ordered.

The committee then presented some amendments to the By-Laws in relation to the election of officers, as governed by Article IV, and the additional sections adopted April 12, 1893, which were to be known as Article IV, Section 1, and to which the following sections were to be added:

SECTION 1. Voting for officers of this Society shall be exclusively by ballots cast previous to the annual meeting. To this end the executive committee shall appoint a special election committee of three, none of whom shall be regular candidates for office, whose duty shall be to receive and count the ballots cast, and declare the results to the society. Should any of this committee be absent, at the opening of the annual meeting the presiding officer shall fill such vacancies from the members present.

SECTION 3. At least sixty days before the annual meeting the Secretary shall forward to all members in good standing a preliminary notice informing them of the nominations for offices made by the executive committee; and at a date not later than fourteen days before said meeting he shall also forward under seal (with notice of meeting and a special addressed return envelope) the official ballot containing all nominations by the executive committee and those by any special caucuses which may have convened for that purpose. The names of all candidates for each office shall be arranged upon the ballot in alphabetical order and, unless otherwise designated, shall be known as presented by the executive committee. The names of all candidates for re-election shall be marked with an asterisk (*), while those nominated by a special caucus of members and certified to by at least ten members who were present, shall be marked with a dagger (†). If any candidate decline his nomination previous to the printing of the ballot, it shall be so designated thereon.

SECTION 4. All nominations by special caucus must be in the hands of the Secretary at least thirty days before the annual meeting.

SECTION 5. Members shall prepare their ballots by making the sign X against the names of the candidates for whom they wish to vote. If in any instance more names are thus marked than there are officers to be elected no name for such office shall be counted. This shall not, however, invalidate the ballot for the other officers.

SECTION 6. All members desiring to vote must return their ballots in the "official return envelope" to the Secretary so that they shall be received by him not later than the day before the annual meeting, and on the morning of said meeting he shall deliver them *unopened* to the special election committee for official inspection and count.

SECTION 7. Candidates receiving the highest number of votes shall be declared elected.

The committee on revision of by-laws presented the following recommendations adverse to the adoption of the amendment:

REPORT OF COMMITTEE ON BY-LAWS.

The committee would report upon the suggested changes, the following recommendations:

Article 5. After the word Vice-President to add an s, making it read Vice-Presidents.

To insert after the words "if present" the words, and for this purpose the person receiving the largest number of ballots for that office shall hold the seniority. To substitute for the words "such person as the meeting may appoint," the words, such members as the presiding officer shall appoint, or the meeting may select.

Article 10. To substitute for the words, "the days of the annual

and semi-annual meetings," the words, the same days as the regular meetings of the Executive Committee.

To insert before the words "they shall report, etc.," the words: they shall verify the medical diplomas of all applicants for membership and report, etc., leaving out the present "they shall."

Article 23. To substitute for Nos. 4 and 5 the following words,

4. For advertising oneself or knowingly allowing oneself to be advertised, as possessing remarkable or extraordinary powers or ability.

5. For any conduct which in the opinion of two-thirds of the members present at a regular meeting, shall be dishonorable.

ARTICLE 24. After the words "two-thirds vote," to insert the words, of the members present at a regular meeting.

Article 25. To strike out the words "and" between Secretary and Treasurer, and insert after the word "Treasurer" the words, and life members.

It is the opinion of your committee that any change inserting a new article after Article 15, is uncalled for, the necessary provision being made in Article 4.

It is the opinion of the Committee that the motion presented by Dr. Rand should be altered in its substance for the following reasons: First, that it is not advisable to introduce voting by mail, as it is for the best interests of the Society that those who share its benefits should be present at its meetings. Second, that it would conflict with the meaning of Article 4, which provides that the Society at (not before) its annual meeting shall elect, etc. And third, that to have one portion of the members vote by mail and another portion by ballot at the polls would work confusion to remedy which no provision is made. And fourth, that it will impose upon the Secretary a large amount of work which should not be included in his duties, and it will violate the secrecy of the ballot.

We would therefore present the following as being in accordance with the present practice and for the best interests of this Society.

Motion made to adopt the recommendations of the committee.

Dr. Scales said that it was a singular fact that only one-half or less of the members were present at these meetings, but that was the fault for the greater part of themselves. If this arrangement can be made, and individuals can come and use their rights and save a great deal of extra work for the secretary, he should be in favor of the motion.

Dr. Rand said that the amendment provided for a ballot by mail exclusively, and he did not see how any confusion could come from such a plan.

Dr. Colby thought the plan violated the secrecy of the ballot and interfered with the rights of a member to cast his ballot with his own hands.

Dr. Rand thought there must be a serious fault somewhere when the majority of the physicians in the State are not members of this Society. In Rhode Island 60 per cent were members; in Connecticut, 60 per cent.; in Maine, that State with such great distances, there were 66 per cent. of the physicians who were connected with the State Society. In Massachusetts, with its 600 or more physicians, only 43 per cent. belonged to this Society. He knew personally of the feelings of the outsiders as to membership here, and he felt and believed that the adoption of the amendments, as proposed, would lead to an increase in our numbers. It gave every man a chance to vote, and allowed the candidate to feel that he had been fairly elected and was the representative choice of the whole membership of the Society, and not that of a minority fortunate to be present at a meeting. The system would save the time of two of the members and the Society itself for a greater part of one session. By its adoption also you did away with one of the strongest objections urged against the policy of the Society.

Dr. Lamson Allen urged the adoption of the amendment feeling that the Society ought to do all it could for those outside. Many of the members living at a distance often planned to come but were prevented at the last moment, but if the changes suggested were adopted, those members have at least the feeling that they have a voice and a vote in the affairs of the Society. This Society was not necessarily made up entirely of those living within five or six miles of this hall, and it should not be made up officially of those within this short distance, but taken from the entire state. There was nothing would chill the ardor of a member of a Society so much as his inability to cast his vote at a time when he might especially wish to do so. The changes were entirely within the scope of the Society to adopt, and there was no substantial reason why they could not be adopted as stated.

Dr. Colby said there seemed to be two different amendments, one written and one printed, at least there were verbal differences, and it would be well to know what they were voting on.

Dr. Jenness said that the receiving of the ballots at midnight might be all right and it might not. You know when you deposit your mail, but the Lord only knew when it would be delivered.

A member said that the greatest interest taken in the Society was by those who were at the meeting, and they showed their interest by this attendance. He thought it would be a mistake to put the ballot in the hands of those who were not interested enough to attend the sessions of the Society.

Dr. Martin said he would favor the amendments for two reasons, first, as a matter of justice to those members of the Society, who did not live within a short distance of the place of meeting, and secondly, for the best interests of the Society itself. He thought some of the objections urged against the adoption of the amendment might be considered as trifling, and rather intended to throw confusion upon the subject. There was no difficulty in arranging the words midnight or day. The point made that those who were present were those most interested in the Society cast an unjust reflection upon a large number of the members. It was not possible to be always present during the short time the polls were open. The effort required to come from Commonwealth Avenue or from 100 to 200 miles within the State was not to be compared for a moment. Every member paying his dues should be allowed to take part in the election of the officers of the Society no matter where he lives. He did not mean that the local members meant any injustice, not at all, but he would avoid confining the ballot to such short hours, and there was not the interest in the distributing of the officers nominated as there should be. He was sure that there would be more interest among the members throughout the state if they could have this privilege. No objection to putting the name upon the ballot or in so far violating the secrecy of the ballot, for if the voter had no objection there was no reason why the Society should have any. He felt that he could safely say that he voiced the feeling of the profession in Lowell in what he had said.

A member stated that he was connected with an organization where the proposed plan was in operation and very successfully so. It was not a medical association but the rule was as applicable. He thought the adoption of this system would do away with the present confusion during the hours of the session, and give more time for other business. He thought a member could do better work when at the Society meeting, by attending to the paper and discussions, rather than to be occupied with watching the time or checking off ballots or voting for officers, while those who have prepared papers are endeavoring to preserve attention.

More attention should be given to the writers of papers, and this unnecessary confusion within the hall done away with.

Dr. Warren thought every member was, or ought to be, interested in the best welfare of the Society, and should be interested in the welfare of homeopathy in Massachusetts. Every member of the profession who was qualified he would like to see in the Society. The resolution presented by Dr. Rand gave everybody an equal chance, worked good to all and harm to none. The rule of taxation without representation had never been a success anywhere. As to how much truth there was in the reports of disaffection it was unnecessary to say, but there was certainly a feeling prevailing very largely that about all the privilege many members got out of the Society was that of paying dues. If we published our transactions it would be some return. It was not a fact that those who were present were those most interested. The voting hours were limited and it was not always possible for those from the western part of the state to be here. If, however, they could send in their ballot they would feel that they had some voice, some representation, in the management of the Society. So far as his personal feelings were concerned he felt that this was a step in the right direction, and saw no reason why anything as just and honest as this move should not be adopted.

Members referred to the present custom among the alumni of the Boston University, and the New York Homeopathic Medical College, who had adopted this rule, in the latter case the ballots had to be in three days before the election, and every one was satisfied with the workings of the rule. They thought that these instances were good precedents for this Society.

The question being called the President said the discussion had rather drifted over two propositions, he would, however, put the question as to the adoption of the recommendations of the Committee on By-Laws, which he declared, on the count of the tellers, lost.

The question was then on the adoption of the amendments as presented, which he declared carried.

On motion the report of the committee as amended was adopted.

The tellers reported the following named as officers for the coming year:

President, Herbert C. Clapp, M. D., Boston.

Vice-Presidents, George S. Adams, M. D., Westborough; John Lambert Coffin, M. D., Boston.

Corresponding Secretary, Frederick P. Batchelder, M. D., Boston.

Recording Secretary, Frank C. Richardson, M. D., Boston.

Treasurer, Winslow B. French, M. D., Boston.

Librarian, J. Wilkinson Clapp, M. D., Brookline.

Censors, Howard P. Bellows, M. D., Boston; Edward P. Colby, M. D., Boston; N. Emmons Paine, M. D., West Newton; Horace Packard, M. D., Boston; N. W. Rand, M. D., Monson.

Adjournment was then had for lunch.

The President called the Society to order at 3.30 P. M. and delivered the annual address.

Dr. Batchelder, in behalf of the Executive Committee, spoke in regard to increasing the interest of the members in the meetings of the Society, and improving its work and moved the following: That during the coming year, as a matter of trial, a special meeting be held in the month of January, the committees assigned to report being such as the Executive Committee may deem best. On motion it was so ordered.

PRESIDENTIAL ADDRESS.

BY HOWARD P. BELLOWS, M. D., BOSTON, MASS.

Ladies and Gentlemen,—Once before I have had the honor of standing before you and formally addressing you. It was eleven and a half years ago, at the semi-annual meeting of our Society, and upon that occasion you asked me to be your orator. I was then one of the younger men among you, and the position which I assumed was that of one looking backwards. With a heart full of gratitude to those sturdy pioneers, our earnest, struggling, self-sacrificing fathers in homeopathy, who bequeathed to us of a younger generation the fruits of their labors and smoothed for us the pathway of a medical career, I turned my glance from the present to the past and, with the desire to render grateful acknowledgment, chose for my subject, "Our Heritage." To-day, with silver threads beginning to show upon my temples, I reverse the view and take the position of one looking straight forwards. My thoughts are full of the obligation which has devolved upon us to extend from our position of vantage and security that present help and future incentive to medical progress which may justly be expected of us by those who are already following in our footsteps. That which we have received we must give in turn, and, unless we are unjust stewards, it must be given with increase. Nor are we to regard this in the light of a mere obligation: it is rather our highest privilege; and with this paramount idea I turn my views to-day from the present to the future, and choose for the subject of my address, "Our Opportunity."

The view of men who continuously labor in any field of usefulness is naturally limited more and more by their immediate surroundings. To secure a truly realizing sense of the relation of our work to that of others, or of how the position which we hold touches that held by others, it is necessary to view the situation from a distance. Then the trend which we are following becomes apparent. We can see whence we have come and whither the path which we may be following is conducting us. If we are not progressing, that, too, is evident; and, more than all, if we are in possession of a position stronger than we perhaps suspected, we will better know how to make use of this position to direct and speed our progress to future successes and to larger fields of usefulness.

It has been my recent privilege, during a period of rest from professional labor, to secure such a distant view. In point of material

space my position was as far removed as the shores of Asia, where, surrounded by a strange civilization, I have felt myself cut off and wholly isolated from our country and all its institutions and from all its modes of thought. But chiefly of advantage was the change in the mental point of view, with all the little incidents of daily practice for the time forgotten, with all the pressing obligations and the depressing responsibilities for the time removed, so that, with rested mind, the mental vision became daily more clear and the general oversight both more extensive and more comprehensive. From surroundings which on every hand proclaim a majestic past — from the templed aisles of Karnac and the ruined temples and tombs of Thebes, where an intricate medical lore emerges from an all but pre-historic past; from Palestine where centuries ago a Jewish ritual enforced a system of hygiene which to-day is hardly equaled, and where the greatest Healer of all the ages walked the fields of Galilee and the streets of Jerusalem; from the land where the evidences of Turkish bigotry and misrule are upon every hand; from the land of Æsculapius where Hippocrates taught his disciples; from the classic soil where Galen ministered to the mighty of the earth — the vision wonderfully clears. Little things recede and petty points of difference seem insignificant. There stand out strongly in mental view the great schools and the more distinctive medical systems of the past, together with the blurring outlines of centuries of vagaries and whimsicalities in medical belief and practice. The good can be better discriminated and approved and the weak and the bad can be better recognized and condemned when one thinks in the midst of such surroundings.

To this line of thought there follows, as its inevitable end, a keen desire, a fervid hope, that the medicine of the future may be wholly different from the medicine of the past. Where in all these receding centuries, so glorious in art and in heroic achievement, appear any medical attainments to which we can point with equal pride or satisfaction? Where in all the remote past appears even the foundation upon which can rest a science of medicine worthy to rank among the sciences of our own day and of the days to come? It is only within the past century that medicine has really begun the march of true progress. With the aid of other collateral sciences the foundation has at last been laid upon which we can build with some hope of its future endurance, even though the superstructure may crumble time and again, in part or in whole. Truly scientific methods of observation and the means of accurately recording, comparing, and classifying observations, have given us results which stand the test of time and repeated experience when applied to the study of anatomy and physiology and pathology. Modern chemistry and microscopy and refined methods of physical analysis have perfected our drug preparations and given us a modern and scientific pharmacopeia. Wonderful ingenuity and technical skill have been exhibited in the invention and con-

struction of our surgical *armamentarium*, and with a knowledge of the principles of asepsis and antisepsis, the surgery of the present day has become one of the marvels of the century. Matters of public health and sanitation, individual hygiene and the prevention of disease, are well understood and wisely practised. Our beloved profession is not to halt or to fail when other professions, so much less worthy, are feeling the impetus of modern thought and discovery. But there is one department in which weakness is still apparent; one department which lags behind all others in the general progress; in which seems to gather and perpetuate itself all the uncertainty and darkness of past ages; in which the practice of medicine still remains essentially an art, and is only beginning to become a science, and that is the department which transcends all others in practical importance for the welfare of the human race — the department of therapeutics. Here it is that doctors differ where most they should agree. Here it is that honest difference in belief or practice, or in methods of investigation, gives rise to feelings of bigotry and intolerance, to animosity and professional ostracism. Yet here it is that the profession as a whole should most cordially unite in a systematic search for knowledge which will place the cure of disease upon a scientific basis and leave it no longer, for the most part, a matter of empiricism.

Our knowledge of the action of disease and our power of diagnosis and of prognosis is already quite sufficient for the most exact scientific investigation along these lines. Our knowledge of the nature and preparation of drugs is likewise quite sufficient for the purpose in hand. The action of these drugs upon the organism of the lower animals, in health particularly but also in disease, is being studied in many laboratories, both here and abroad, and the results are being faithfully recorded and compared and put to the test upon the sick. These investigations are all along the line of the old empirical use of drug action, the employment of the secondary effect of the drug, in more or less massive doses, to counteract or offset the action of disease on the principle of an opposing or contrary power. That such a power and such a mode of drug action exist, and that drugs may thus be beneficently used, few among us will be willing to deny. But that this is the only way in which to employ drug action, or that in this way the *best* therapeutic results are to be obtained, none among us, I believe, will be willing to admit. The effort to make more scientific the old therapeutical uses of drugs by the study of physiological drug action in laboratories is hardly likely to satisfy the demands of a modern science of therapeutics, and many of its investigators are already turning away to experiment, instead, in the direction of serum-therapy. It is right that both these lines of research, and all others which promise equally, be followed faithfully to their last logical deductions in the search for truth and the best attainable therapeutical method, and all men should await the results in a spirit

of fair-mindedness. This we concede to others and this, in return, we demand from others in relation to still different lines of research, whether these be our own investigations as individuals or as members of a school.

Ladies and gentlemen, we meet here as members of a distinct therapeutical school. The sole reason for the existence of this society, of which we are members, is our belief in a therapeutical method which differs from that of the dominant school and which has proved an offence to it. We believe that the best therapeutical effects are obtained from drugs when their primary action is employed rather than their secondary action; that they are best administered in minute and attenuated doses rather than in those more crude and massive; that the best indications for drug exhibition are obtained by experimentation upon the healthy human organism rather than upon the sick or upon the lower animals, although all information in regard to the pathogenetic power of drugs obtained through animals is welcomed and utilized in a broad way; and finally, we believe that among the effects of drug action in the cure of disease the most beneficent are obtained, not from their power of direct opposing or contrary action to the disease, but in accordance with a more definite and scientific principle (or rule of choice, if you will) which is embodied in the words *similia similibus curanter*.

It is this last position which has given chief offence to our colleagues of other schools, and which has forced us to band ourselves into separate medical societies and to found separate medical colleges and hospitals for the purpose of mutual support and advancement. It seems to be considered an unwarrantable assumption that we possess a definite rule for the choice of drug action in the treatment and cure of disease. And yet just such a guiding principle in therapeutics is the one thing which is chiefly desired by all who have the future of medical science most at heart. It is the object and the aim of therapeutical investigation everywhere among those of all schools. May the fault not lie somewhere at our own feet, in some measure at least, if we have not succeeded in convincing the fair-minded among our colleagues that we are in actual possession of a definite guiding principle in therapeutics such as has long been sought; a principle which we apply constantly, day by day and year by year, in our practice, with practical results which will stand and justify the world's closest and most exact scrutiny? We do not claim perfection in the application of this principle. Some of us do not yet claim perfection even for the principle itself, (for who knows but that in following this, sometime in the future of science, we may be brought to the knowledge of one still higher and more exact and nearer to the eternal truth?) but that this is the path in therapeutics which is better worthy of being followed and studiously and laboriously developed than any other which is open for investigation we heartily

and unreservedly believe. Perfect sight is given at once to no man or to no body of men. There are first glimmerings of light, a few guiding rays by the aid of which and in following which we are conscious of a firmer tread, of a rising path, of increasing strength and ability to climb. Such light and more we have already received. We know from our own results, from our practical successes, that we are following a guiding principle in the choice of our remedies which seldom fails us and which we believe will fail us still less, or never, when our knowledge of drug pathogenesy is more exact and is freed from error. Our patients know what results are obtained by their relief from suffering and their recovery from disease, as increasing thousands of the most intelligent of our citizens attest by their gratitude and adherence. The reading public know by the reports of our dispensaries and our hospitals that we are making a proud record in medical statistics and literature. But with all the progress made thus far in the demonstration of our ability to accomplish in practice what we profess in theory, and despite our recent rapid gains, we are not yet the leading school of therapeutics in point of numbers and influence, and among our professional colleagues of other schools there is yet no general recognition of the scientific value of our claims. We are every one of us specialists in therapeutics. We know and we feel our power to advance the science of therapeutics to the benefit of the whole profession of medicine. Can we, then, be satisfied or rest for a moment content until we have presented these claims, again and again, in a manner so scientific and so convincing that their acceptance will be forced even upon our opponents?

Upon whom devolves the responsibility of this effort? The homeopathists of England, of Germany, of France, of Belgium, of Europe in general, are fighting a good fight, but they are handicapped in their efforts by the lack of state recognition and university support. The great public clinics and institutions, the military and civil appointments are all in other hands than theirs, and their strength has never been equal to the creation of fitting opportunities for public demonstration or instruction by means of private endowment, or to any adequate enlightenment or control of public opinion. In the various colonial settlements of England, notably in India and Australia, somewhat greater liberty in medical matters is accorded than in the mother country, but it is yet too early for anything beyond a vigorous local growth to be expected. In other parts of the world, in the Spanish American republics, for instance, there is here and there a sporadic homeopathic growth, but nothing in the way of propagation is at present to be looked for in any of these countries. Under the Republican liberties and institutions of our own United States, however, the case is wholly different. Here the power of the people is paramount, and public recognition has been secured by means of myriad successful cures wrought for years among the people themselves in

every State of our Union. Thus has arisen a public opinion favorable to our cause, and following upon this comes friendly and helpful legislation. Public trusts and private bequests place us year by year in positions more independent of our adversaries, and more powerful for the extension of our influence. Here centres the hope of homeopathy for the future. Upon us rest the eyes of homeopathists the world over. To us, here in the United States of America, they look for the highest development and the most searching revision and the widest propagation of our beneficent system. Look at the position of strength which we have attained and realize that this is the measure of our responsibility to the generation which follows us, the measure of our opportunity to better the whole future of medical science.

Are we improving this opportunity? Are we so upholding and upbuilding the principles and practice of homeopathy that the influence of our work will reach and carry enthusiasm to the next generation? Or are we resting content with the therapeutic laurels which we have already plucked and with those which have been handed down to us from the generation past? We are cultivating all manner of medical and surgical specialties. We are following all branches of collateral science. In the midst of our successes in the many varied directions of professional activity let us never be beguiled from our own distinctive work. Let us never fail to recognize as homeopathists the foundation rock upon which we build. Let us never cease or forget, for the sake of the great future, to forward the interests of a pure, scientific and progressive homeopathy.

REPORT OF NECROLOGIST.

FRED'K A. WARNER, M. D., LOWELL, MASS.

NATHAN R. MORSE, A. M., M. D.
Died August 5, 1897.

Since our last annual gathering, one of our most active and energetic members has gone out from among us to join the great majority. No more shall we hear the stirring words of Dr. Nathan Ransom Morse.

Nathan Ransom Morse, A. M. M. D.. was born in Stoddard, N. H., Feb. 20, 1831. He was the oldest of a family of eight children, three of the four sons devoting themselves to the study of the healing art. Dr. Morse was descended from Samuel Morse, the distinguished Puritan who emigrated to the New World in 1635. He entered Amherst College in 1853 and graduated four years later. During his college course he was interested largely in geological work. He studied for a time at the Harvard Medical School, but completed his professional preparation at the University of Vermont, from which he graduated in June, 1862. After practising three years in the town of Reading, Dr. Morse settled in Salem, remaining till the time of his death. He acquired reputation as a physician which was an enviable one and his services were often called upon outside of his immediate practice. Dr. Morse was one of the founders of the medical department of Boston University, subscribing $1,000 towards this object. In the Boston institution he was professor of the diseases of women and children from 1874 to 1879. He was recording secretary of the Massachusetts Homeopathic Medical Society during 1878–9, edited Volumes IV and V of the Society Transactions, and was its orator in 1874. He had been secretary of the Essex County Homeopathic Medical Society and later its president. Had also been president of the Massachusetts Surgical and Gynæcological Society, and was a senior member of the American Institute of Homeopathy. In the latter organization, Dr. Morse made the motion to admit women to membership, it being, in consequence, the first medical society in which women were eligible. Dr. Morse was married in 1859 and again in 1864, leaving five sons and one daughter. Dr. Chas. W. Morse, one of his sons, is now acting as his successor after being well equipped for the work at home and abroad. Dr. Morse was a man of acute and vigorous intellect, and rugged strength of character, was positive in

his opinions and resolute in maintaining them, but of a genial, kindly and sympathetic nature. No worthy application for assistance went unheeded with him, and with the skill of the physician were mingled the kindly offices of the personal friend. In this capacity few have excelled him. In every circle where he moved throughout his busy life, he was the central figure, a strong bond of union, the loss of which will be the more keenly felt as time rolls on.

WILLIAM H. LOUGEE, M. D.

Died November 18, 1897.

Again we have to report the death of a veteran member of the Massachusetts Homeopathic Medical Society, Dr. William H. Lougee.

Dr. Lougee died very suddenly at his home, 369 Haverhill St., Lawrence, Mass., Thursday evening, Nov. 18, 1897. During the day he made his usual round of calls, attended to his office practice afternoon and evening, reaching home thirty minutes after nine o'clock and complained of illness to his housekeeper. During the day he said too, that he felt oppressed for breath. His condition seemed so alarming that medical aid was at once summoned, and the doctor reached his side in time to find him breathing his last. Dr. Lougee's health had not been of the best for several years. Four years ago he was confined to his home for a considerable period but finally so far improved as to be able to resume practice. Dr. Chas. W. Morse of Salem writes this concerning Dr. Lougee : —

" During the summer of '93 Dr. Lougee was at Baker's Island, and was supposed to be in his last days on earth. He suffered greatly but patiently with deep diabetic ulceration of the legs. Though confined to his bed he seemed to know everything that transpired on the island as if by some unknown power. Ex-President Harrison stopped on the Island about that time and learning of Dr. Lougee's illness called upon him and talked with him pleasantly for several minutes, shook his hand kindly and warmly, wishing him a speedy recovery, whereupon Dr. Lougee, quick as thought, said, 'Yes, Mr. Harrison, I am like the Republican party, getting better fast.' "

Dr. Lougee was born at Hanover, N. H., Feb. 13, 1832. He attended the public schools and afterward was a student at Pembrook Academy. Before attending the Philadelphia Homeopathic Medical College, he studied with Dr. Morrill of Concord, N. H., and in

Methuen. He graduated from the Philadelphia Medical College in the spring of 1857 and began practising medicine the following August in Lawrence. During the seventies he spent two years in Berlin and Vienna in post-graduate studies, mostly in gynæcology. He was a close student in medicine and surgery and labored earnestly in the field of his chosen profession.

He had an immense clientage and was regarded as one of the most prominent physicians of Lawrence. His death follows quickly that of his wife who passed away September 20th last.

Dr. Lougee was a member of the Phœnecian Lodge of Masons, of the Massachusetts Homeopathic Medical Society of which he was president during one year (1880), also of the Massachusetts Surgical and Gynæcological Society of which he was president at one time. Notwithstanding his large practice, he made great sacrifices to attend every meeting of the respective medical organizations to which he belonged, and was rarely absent.

Dr. Lougee was a warm friend of the Boston University School of Medicine, as seen in his will, in the form of a bequest, which gives to the College on East Concord Street his library, instruments and medicines, to the Homeopathic Hospital he gives one thousand dollars to furnish a ward.

REPORT OF THE COMMITTEE ON DISEASES OF CHILDREN.

I. Some Personal Experiences in Deformities of the Soft Tissues. A. H. Powers, M. D.

II. Club Foot; its Treatment, with Demonstrations of Dressings and Illustrative Cases. George H. Earl, M. D.

III. Lateral Curvature of the Spine; its Prevention and Gymnastic Treatment. A. G. Howard, M. D.

SOME PERSONAL EXPERIENCES WITH CONGENITAL DEFORMITIES OF THE SOFT TISSUES.

A. H. POWERS, M. D.

The topic as given in the official program is not just as I would have it and instead allow me to amend it so as to read some Personal Experience with Congenital Deformities of the Soft Tissues.

Congenital deformities are very frequently observed and every one here present can recall such cases by the score. Often the cause ascribed is the time-honored one of maternal influence, and among the laity and some benighted ones of the profession this seems to be an ample explanation.

It is not my purpose to enlarge on the causes of these deformities, but wish to suggest that the more carefully we study fœtal development and growth the more nearly can we understand the mode of origin, if not the cause.

I must confess that so far as the ultimate cause is concerned there is little known or written on the topic, if I can judge by what I have been able to find; but in the development of the fœtus causes are manifest which cause an arrest of development or a distortion of normal parts. The main difficulty in studying this subject arises from the fact that the first few weeks or months of pregnancy are much the most potent in causing these deformities and when they possibly might be studied in the products of an early abortion they are lost because the parts are too small to attract the attention of any but a well trained eye.

I must urge that we each of us allow no opportunity to escape which might prove of benefit in this line of study, and the query arises

in my own mind if possibly these deformities might not be found in a larger proportional number, in cases of abortion, than is found in the products of completed pregnancy.

And the first class of cases to which attention is called are those congenital cysts of the forehead varying in size from a small pea to that of a hen's egg when fairly developed. These seem to come from the infolding of an epithelial surface of one or more of the pharyngeal clefts.

They may not be of much size till adult life is reached, and then gradually increase in size so as to be very unsightly.

Removal is usually easy except that a hemorrhage is likely to be profuse and hence the dissection of the sack may require considerable time. I have occasionally heard it said by the laity that these growths should never be disturbed, possibly because in a few rare cases they are true menigoceles. In several cases which have come under my care these cysts seemed to have remained quiescent till adult life, and then they began to grow.

When we come to the oral cavity we at once reach a group of deformities which are important and quite well known. Hare-lip, cleft-palate and tongue-tie are usually well cared for, and I hardly need urge early operative interference. Here arrest of development explains most of the deformities and the early correction will often result in almost complete recovery. There is in early fœtal life a structure known as the thyro-lingual duct. This, as the name implies, connects the thyroid gland with the mouth at the base of the tongue. In rare cases this fails to become obliterated, and in two cases which have come under my care there was found a sinus opening upon the cutaneous surface of the neck just in front of the thyroid cartilage which extended downward nearly to the gland, and there was a slight discharge of mucus which was constant. This discharge had persisted for years in spite of the many expedients tried, and in one of the cases, was cured only by a careful dissection, removing all the membrane. In a case somewhat similar there was found a sinus opening just at the anterior border of the sterno-cleido mastoid muscle, about an inch above the sternum and the probe passed down to the neighborhood of the trachea.

This was cured by repeated cauterizations with carbolic acid crystals. In this connection I may as well refer to the case which is here today, in which there is a congenital absence of the thyroid.

This little girl who is three years of age is probably a semi-cretin. When she first came under my care she was in appearance and intelligence a child one year old. She is having thyroid feeding.

There is a class of deformities which are dependent on lack of or maldevelopment of the pharyngeal arches.

A deformity I have several times seen is an extra lobule or lobe in the region of the ear. In the case I show you today this outgrowth

is situated lower on the neck, and I had one case where there was a small cartilaginous growth on either side of the neck in much the same position as this case shows. At times the pharyngeal clefts do not coalesce and we then have a pharyngeal fistula.

Again, in the union of two of the arches there may be infolded a portion of epithelial surface which results finally in the secretion of a fluid, with a resulting cervical cyst. These are called hygromata, and for their cure there is usually required the dissection of the limiting membrane and its removal. Carcinoma is said to arise at rare intervals from these infolded portions.

Abdominal Wall. The external genitalia are often the location of deformities, and I have two cases illustrating forms of deformity.

Cases of hypospadias are not uncommon, and certainly in the severe forms such as the one here shown there is a demand for early interference. I have been surprised at the frequency with which some slight deformities of this class appear. These are the cases where nothing has been done and yet where operation is usually easiest performed and necessary to prevent life-long infirmity. The deformity is often so slight that no notice has been taken of it till adult life has been reached and then the patient bears for years the constant irritation rather than expose his infirmity and subject himself to a trifling operation. I can hardly urge too strongly that each child should be carefully examined and every defect remedied as far as possible. In the last case which is present we meet a still rarer class of deformities, namely, that of a displaced testicle. All of us are fairly well acquainted with an undescended testicle which is almost always situated on the right side of the body. In this case the testicle is displaced and really descended farther than normal.

CONGENITAL CLUB-FOOT.

GEO. H. EARL, M. D.

The subject selected by this bureau for consideration being congenital deformities, and being asked to present that portion of the subject which related to boney deformities, and which also came within the province of the orthopedic surgeon, I easily arrived at "club-foot," as a topic.

The great majority of congenital club-feet are cases of equino-varus the heel and inner border of the foot raised, and it is the treatment of that form only which will be considered.

There is little or nothing new in the treatment; but in view of prevailing skepticism in many quarters, and not a few instances of failure to correct, it seems worth while to review and summarize the treatment.

The writer believes that any case of club-foot of the variety named can be cured.

The treatment, briefly stated, consists in putting the foot straight, and holding it straight until all tendency to relapse is overcome.

The "putting it straight" is accomplished by manual correction, tenotomy, fasciotomy, open incision of resisting soft tissue, and removal of bone.

The milder cases yield to simple manual correction, and strapping with adhesive plaster, or bandaging with a common roller bandage.

The more severe cases, require a combination of most, or all of the operations enumerated above, and the retention for weeks or months in rigid plaster of paris dressings.

Once the foot is put straight the battle is well started, but it is only started. The real fight, and it often amounts to that, is to prevent relapse.

As the foot is used in walking and the leg muscles develop, as they have not had opportunity or occasion to do before, the same tendency or cause, whatever it is, which raised the heel before birth, acts again and continues to act for months and years.

The younger the patient, the milder the operation, but the greater the tendency to relapse. The older the patient, the more severe the operation, but the tendency to relapse is correspondingly lessened.

Too much stress cannot be laid upon the value of treatment by manual correction.

A foot which can be put straight, and held so by the operator's hands, can be entirely and permanently cured without operation; but such a case will usually require longer retention by apparatus than an operative case.

In an operative case, *i. e.*, one which cannot be put into a correct position with the hands, enough should be done, so that the foot can be held in a slightly over corrected position without undue force. By that I mean so that a plaster of paris bandage may be applied without danger of making a pressure slough.

The same precaution should be observed in manually correcting a non-operative case.

The mildest operative treatment consists in a tenotomy (sub-cutaneous) of the tendo Achilles; the next, of the plantar fascia, also sub-cutaneous.

The next is the open incision of all resisting soft tissues, on the inner side of the foot, "Phelps" operation, which is well known, and need not be described here.

Lastly, the foregoing operations combined with forcible manual correction, failing to bring the foot into proper position, recourse must be had to the more severe bone operation.

This consists in removing from the outer side of the foot sufficient bone to allow the foot to be placed in a correct position.

This is done by removing a wedge-shaped piece from the tarsus, *i. e.* from the anterior portion of both the os-calcis and astragalus, the head of the wedge being, of course, toward the outside of the foot.

Removing the bone as far back in the foot as possible, avoids undue shortening of the foot.

In making a sub-cutaneous tenotomy, a practical point of value is to enter the knife through the skin at some distance from the point at which the cutting is to be done, so that the whole edge of the blade may be used instead of the point alone, and also to avoid enlarging the opening in the skin, with the heel of the blade. There is less danger too, of wounding underlying structures.

The retention of the foot in a correct position without inflicting pain, is the real tug of war.

No greater mistake can be made than to operate a club-foot and then let it go as practically finished.

The plaster of paris dressing applied over a thin layer of sheet wadding, is undoubtedly the best method of retaining the foot in position.

For babies who are not walking this should extend from the tips of the toes, a sufficient distance above the knees to keep the dressing from being kicked off. That means that it should go as high on the thighs as you can get it, and the thighs should be at right angles to the legs.

In a case which is being treated by manual correction alone, the adhesive plaster strapping is sufficient until the foot can easily be held straight, then plaster of paris, until all resistance is overcome, then a Brackett shoe.

In operative cases in children, plaster of paris for a month or two, and then a Brackett shoe.

The Brackett club-foot shoe was designed by Doctor E. G. Brackett of Boston, and is a most efficient device. It consists of a sole plate provided with a lip turned up alongside the great toe and heel. To this plate is rigidly secured an upright, extending all the way to the hip. This upright passes up the inner side of the leg, *without* joint at the ankle, to a point just below the knee, where it passes in front of the leg to the outer side and up to the knee, where it is provided with a joint which allows normal motion of the knee.

From this point it extends up the outer side of the thigh to a point just below the crest of the ilium, where it is provided with a pivoted plate, straps and buckles.

It is used as follows: A piece of adhesive plaster is applied to the posterior surface of the leg, extending three or four inches below the heel. The foot and leg are next wrapped in sheet wadding.

The shoe, fitted with a piece of felt the size and shape of the sole is applied to the foot in its abnormal position, and the heel pulled down into it and secured by means of the strip of adhesive sticking to

the under side of the sole plate. Then a few turns of a roller bandage made over the head of the astragalus and the heel of the shoe.

Now the foot is secured in the shoe, the sole of the foot being held in contact with the sole piece of the shoe. Next the upright is carried into place along the inner side of the leg, and by its lever action, the foot is brought into correct position. Then a plaster of paris or silicate bandage is applied over all as high as the knee.

This absolutely secures the foot from moving, twisting, or rolling, in the shoe and the heel from drawing up, all of which things it will inevitably do in any removable device which holds it without inflicting pain. The straps at the top are buckled around the pelvis, and prevent the child from "toeing in," tightening the posterior strap, turning the toes out by rotating the entire splint outward.

This shoe is re-applied once in three or four weeks, and the child walks on it without danger of interfering with its efficiency in any way. It has the advantage too, of being applied only by the surgeon, so that he knows exactly where to place the responsibility in case of trouble. Later, the same apparatus can be attached to a pair of common laced boots.

LATERAL CURVATURE OF THE SPINE, ITS PREVENTION AND GYMNASTIC TREATMENT.

A. J. HOWARD, M. D.

Scoliosis is described (Am. Text book of Surgery) as "two or more lateral curvatures of the spine, with their convexities on opposite sides of the longitudal axis of the back. The vertebræ of the region are also otherwise changed in their relations to the same axis, being rotated so that their spinous processes point toward the concavities of the lateral curvature."

Lateral curvature of the spine is a subject which should command our attention, for many reasons. It is a very common deformity. It is a deformity which, if not corrected, is apt to continue increasing to the detriment of the general health of the child; in that the lung capacity is decreased, or does not increase as it should, with the increased growth in other directions, resulting in improper nutrition and retarded development.

The deformity becomes a fixed one; when a complete cure is very difficult or is an impossibility, and is a constant annoyance to both patient and friends.

The gymnastic treatment of scoliosis in children, not only cures the deformity, but increases the general physical development, health, strength and vigor of the child in every way.

Lateral curvature of the spine is the most common deformity met with in children (unless we consider rounded shoulders a deformity.)

Dr. J. Gardiner Smith, for several years director of physical training in the public schools of New York City, stated after examining several thousand children in those schools, that one-tenth of all the children examined had lateral curvature in some degree. Probably an examination of our Boston children would reveal corresponding figures. In country schools where the children are accustomed to natural play and a certain amount of varied work at home, there are fewer cases.

From personal observation of several hundreds of boys (8-16 years) entering the gymnasia of the Y. M. C. A's. of this state, and in one Orphan Boys' Home I have found lateral curvature to be very common. I can not give the exact percentage, but it was certainly not so large as Dr. Smith's figures. Dr. Smith examined both boys and girls, and the deformity is more common in girls than boys. The most common curvatures are those of the dorsal region with the convexity to the right. The compensatory curve is usually below, in the lower dorsal and lumbar regions.

There may be a third and smaller curve in the cervical region, corresponding in its direction, with the lumbar curve — always opposite to the primary curve. More than three curves are rarely found, but are mentioned by some writers. There is more or less rotation of the vertebræ so that the spinous processes point toward the concavities of the lateral curvature — the ribs on the side corresponding to the concavity are depressed and the shoulder is lowered. The scapulae are displaced, because of this difference in the shoulders and ribs and as a result of a weak muscular system.

The chest is usually flat or there may be an abnormal prominence of one side.

These subjects are mostly mouth breathers, and have weak lung power. The intervertebral disks are depressed on one side and thickened on the other so as to make them wedge shaped. This is a result and not a cause of the deformity.

Etiology. 1. Weak or unilateral muscular development, from a lack of proper exercise.

2. Lack of nutrition.

3. Faulty position in standing, sitting one-sided on chairs in school or at the piano, side-saddle riding on horse back, carrying books under one arm, weights on the shoulder, strong and unequal tension from tight stocking-supporters and clothing, improper positions in bicycle riding, in fact any habitual onesided position.

4. Unequal length of legs, causing an obliquity of the pelvis.

5. Infantile paralysis, or muscular atrophy of one side.

6. Caries or diseases of the vertebræ and rickets.

And there may be other causes less frequently met with.

Prevention. To prevent scoliosis, a child should be well nourished and have good physical training. Proper food, natural play, sunshine, fresh air and rest.

These are the most important considerations in the prevention. Of course, if the child has a short leg we must build up the sole of the shoe on the foot corresponding to the short leg. If infantile paralysis or muscular atrophy these diseases should receive their proper attention that scoliosis may not develop.

Gymnastic Treatment. Accompanying all cases of scoliosis in children, there is an unequal development of the muscles of the back, and usually the general muscular development is very poor, and the child is poorly nourished. It is noticeable that the spinal muscles are stronger on that side corresponding to the concavity, and about the first thing to be considered in the treatment is prescribed exercise. For no amount of braces, jackets, corsets or other supports can take the place of well developed muscles.

In beginning the gymnastic treatment of scoliosis, the greatest care should be taken that very weak muscles are not strained. This should not occur with proper exercise. The first exercises should be given to improve the carriage and tone up the muscles and prepare them for real curative work, for if we start them in with severe exercises the patient becomes discouraged, confused and lame.

And I can not lay too much stress upon the position of the patient during treatment, and the execution of each and every movement, for with the class of cases under consideration, the greatest care and attention is required that the exercises are properly carried out.

Position is of first importance, for a really beneficial exercise may result in positive harm if executed by the patient while in an improper position.

The instructor should place the patient in proper position and explain the importance of it, and should impress upon the parents the importance of this.

Take the child out of school and discontinue violin or piano practice. Give light varied gymnastics to tone up the muscular system and prepare the patient for the advanced work.

Do not trust the parents to give the exercises to the child, but all these efforts should be superintended by the physician or a competent instructor, especially during the first weeks of training.

Fifteen minutes exercise is enough for each of the first few lessons and there should be frequent rests. After the child becomes accustomed to the proper performance of all exercises, three or four lessons should be given daily.

I will now illustrate some of the exercises which I have found to be beneficial.

1. Respiratory exercises.
2. Lying on back (*a*) arm movements overcome influence of gravity; (*b*) rising to sitting position (hold feet) bells.

3. Lying on abdomen, raise.
4. Standing position: Hands on hips, (*a*) rotate body, (*b*) bend sides and back, (*c*) rotation, (*d*) back neck work, (*e*) reaching palms up, (*f*) roll shoulders (*g*) breathing exercises, (*h*) arm movements.
5. (*a*) Far-out reach, (*b*) walk a crack in floor or board.
6. Chest weights.
7. Wands.
8. Loin pulleys and wand.
9. Suspension — ladders, rope bar trapeze. Sponge bath, graded.

DISCUSSION.

Dr. J. E. Briggs said that in the discussion of the treatment of club foot we had to consider two distinct divisions, the one being congenital, the other an acquired form. The congenital form spoken of usually came as an equino-varus, and the cases shown by Dr. Earl were of that variety; in fact three-fourths of the cases of congenital talipes were of the equino-varus form. The other division, the acquired form, was one of great importance and naturally of great interest to us, and he would speak briefly of that variety. We had this condition as a result of disease of the nervous system, being usually due to anterior poliomyelitis. Here we had as a result of the paralysis of the anterior tibial muscle, a case of equinus; in paralysis if the gastrocnemius, a calcaneus. If the anterior tibial muscle and the pereneals were involved we had talipes equino-varus. The cause of congenital talipes was probably not definitely known, but was considered to be due to retarded rotation in utero. In the acquired form there was no doubt as to the cause being, as before stated, myelitis anterior. The treatment of acquired club-foot differed somewhat from that of the congenital form. In the latter we had conditions due to growth and development, changes in the structure of muscles, ligaments and especially bones; while in the acquired form we had, on the other hand, usually no material change in the bone, the trouble resulting from contractions of the muscles, distorting the foot to a greater or less extent, so that this form rarely required surgical interference, except a possible tenotomy, but no extensive operative measures, such as removal of bone and resections, so frequently necessary in the congenital variety. In the acquired form of talipes the nerve supply has become diminished, and we had in consequence degenerated tissue. We had to be careful in the treatment by mechanical means that we did not get strangulation and sloughing in this weakened tissue. He remembered one interesting case while he was an interne in the hospital, that of a workman who fell from a scaffold while at work on the college building. He had a dislocation of the spine, which was promptly reduced, but paralysis of the lower extremities followed, involving also the functions of the bladder and bowels. These troubles gradually cleared up, leaving, however, an equino-varus, which was operated upon later, and he was now able to go about with a cane.

REPORT OF THE COMMITTEE ON CLINICAL MEDICINE.

I. Bright's Disease. James Krauss, M. D.
II. Causes of and Prophylaxis for Bright's Disease. J. J. Shaw, M. D.
III. Phosphoric Acid in the Urine; its Sources and Quantitative Estimation. F. P. Batchelder, M. D.

Dr. David W. Vander Burgh, of Fall River, presented by request the report of an interesting case of "Intussusception of the bowels, with sloughing of the dead tissue."

BRIGHT'S DISEASE.

JAMES KRAUSS, M. D.

When we consider the large number of sudden and gradual deaths that result from renal disease it is really surprising that before the days of Bright so little was known about diseases of the kidneys. It is just about seventy years since Richard Bright of London published his famous "Report of Medical Cases selected with a view of illustrating the symptoms and cure of diseases by a reference to Morbid Anatomy," and from that time his name became attached to a class of renal diseases whose chief clinical characteristics were to be found in the discharge of albumin in the urine and in the accumulation of fluid in the subcutaneous tissues and the serous cavities of the body. The term Bright's Disease is really a misnomer. Bright himself knew that he was describing not one disease, but rather a group of diseases: and whether we approach our subject from an anatomical, histological, or a clinical standpoint we are, in every case, confronted by several diseases which, in spite of certain common characteristics, are yet sufficiently distinct to be classed as individual and separate diseases. If, then, we retain the name of Bright in connection with renal disease it is much more to the point to speak of Bright's Diseases rather than of Bright's Disease.

A diagnosis of Bright's disease means absolutely nothing. What we must know is the form of Bright's disease. If we are told that a patient suffers from an eruptive disease we confess at once that we are left in the dark by such a statement. There are so many eruptive

diseases, and we naturally ask which one of these is meant. But yet we sometimes diagnose a case as Bright's disease, although such a diagnosis is not any clearer than the diagnosis of eruptive disease.

The question, then, arises: "What is Bright's disease?" for upon this definition depends the grouping of the several diseases that deserve to carry the name of Bright.

The first and most important symptom of Bright's diseases is albuminuria. It is usually by an examination of the urine that our attention is first called to an affection of the kidneys, for the diseases of Bright are usually painless diseases. If pain occurs at all it is a late symptom and then is mostly due to renal œdema. These diseases are also usually afebrile diseases, and thus the patient may go on ailing for some time before his urine is examined and the albumin in the urine is discovered.

But albumin in the urine does not necessarily mean a disease of Bright or even of the kidneys. It may be a symptom, for instance, of heart disease.

We know that the secretion of urine depends upon the blood pressure in the arteries, and the blood pressure is regulated by the contractions of the heart. If the heart is strong and healthy, the urinary secretion will not be impeded, it will take place, other things being equal, in a normal manner; but let the heart grow weak from valvular, muscular, or pericardial disease, the blood pressure in the Malpighian glomeruli becomes instantly diminished, there results an unusual accumulation of blood, and passive congestion of these renal structures manifest itself by albuminuria, œdema, and cyanosis.

It is very important that we should not mistake this congestive albuminuria for one of the Bright's diseases. We must remember that it is not even a kidney disease; while on the other hand, all the diseases of Bright are primary renal diseases.

Again, albumin may appear in the urine without any appreciable cause. Such a condition has been known, since Leube first described it, as physiological albuminuria. It may be constant for some time; or it may be intermittent, as happened in the following case: —

Mrs. D., age fifty-five, lives on the income of her estate. As she has overdrawn her account the attorney of the estate directs her to take out a life insurance policy in order to reimburse the estate. But the medical examiner refuses her insurance because he finds albumin in the urine. The attorney cannot believe it since his client had been examined for life insurance the year before and was accepted. He, therefore asks her to be re-examined. Eleven days after the first examination the medical examiner finds the urine free from albumin.

The attorney then comes to me and asks me to examine the urine of his client. I direct his client to furnish me with two samples of urine, the morning urine and the evening urine, each to be passed after a thorough vaginal douche. The evening urine was free from

albumin, but the morning urine contained a small quantity of it. The quantity was somewhat less than one per cent. There was no nephritic sediment. I have had the patient now for three months under observation, but no sign of nephritic, cardiac, arterial, or retinal disease has yet appeared. Indeed, she appears to be in perfect health.

While I believe that I am justified in regarding this albuminuria to be physiological, yet I do not overlook the possibility that the albumin may be due to latent nephritis, for it is a well-known fact that latent nephritis may for a long time have the single symptom of simple intermittent albuminuria.

When, therefore, we find albumin in the urine, two questions press themselves forward for answer : —

First, is the albumin a physiological or a pathological occurrence ?

Secondly, if pathological, does the albumin result from disease of the kidneys or from disease of other organs than the kidneys ?

We may say that the presence of a pathological condition at once decides against physiological albuminuria. Albuminuria may be a symptom of diseases of the lungs, of the heart, of the blood, of abdominal disease exerting pressure upon the inferior vena cava, of hepatic diseases with icterus. Albuminuria may accompany diabetes mellitus. It may be present in intestinal diseases with diarrhœa, in cholera, in lead colic and other forms of poisoning ; in various nervous diseases, especially epilepsy and tetanus ; in certain febrile diseases ; in pregnancy ; and it may follow temporary occlusion of the ureters. In all these conditions, however, albuminuria is a subordinate symptom. It is not the result of organic changes in the kidneys as it is when it occurs in Bright's diseases.

These organic changes take the form of inflammation, of œdematous swellings, of atrophy ; and according as these changes predominate in the glomeruli, the tubular epithelium, or the connecting tissue that binds the tubules and the vessels firmly together we obtain the clinical pictures of glomerulo-nephritis, parenchymatous nephritis, or interstitial nephritis.

It is necessary that we pause for a moment for the consideration of these different varieties of renal disease.

Glomerulo-nephritis is responsible for a large number of sudden deaths, and hence should not, as it so often is, be overlooked. The serum-albumin that escapes through the walls of the inflamed glomeruli is out of proportion to the absorbing power of the epithelial layers of the urinary tubules, and hence appears in larger quantity in the urine than we find it in secondary albuminurias ; but as the tubular epithelium is not affected we find no further evidence of nephritis in the urine, unless, perhaps, some hyaline cylinders. But hyaline cylinders are not characteristic of glomerular disease any more than of other albuminuric disease. They simply show that serum-albumin has to a certain extent become moulded into shape within the urini-

ferous tubules, and this may happen to albumin in any disease. But the epithelium of the glomeruli themselves suffers, swells, looseus, and accumulates in powerful layers within the Malpighian capsule and, as a result, we have annuria, and, so often, death. For practical purposes, we may say that when the albumin is more than five per cent., when it shows no other than hyaline cylinders, when the urine is scanty, and of high specific gravity, we have the picture of glomerulo-nephritis.

In parenchymatous nephritis, the tubular epithelium degenerates and is shed, just as the epidermis is shed in scarlet fever. The renal epithelium appears in the urinary sediment in isolated cells or in cylinders, *i. e.* tubular moulds or casts. These epithelial cylinders are absolutely characteristic of parenchymatous nephritis.

When the epithelial cells are clearly defined or, at the utmost, are only shrivelled, we have acute parenchymatous nephritis.

When, besides epithelial casts, we observe blood casts, and the blood corpuscles are of the kind known as microcytes, we have an acute hemorrhagic nephritis. The hemorrhage, of course, is parenchymatous and distinguishes the hemorrhagic variety of parenchymatous nephritis from the catarrhal variety.

When the epithelial cells show disintegration and the casts are covered with disintegrated epithelium and granules, forming what is known as granular casts, we may affirm that a given case of acute parenchymatous nephritis is in process of becoming chronic.

But when the renal epithelium shows fatty degeneration, it makes no difference what contradictory symptoms there may be, it is absolutely diagnostic of chronic parenchymatous nephritis.

Fatty degeneration is, indeed, the dominating pathological character of all of the Bright's diseases ; and, for this reason, if there were no other, the lardaceous or waxy kidney finds a place in the group of Bright's diseases. The waxy kidney is closely allied to chronic parenchymatous nephritis in more senses than one. These two diseases may share the same causes and may be present at the same time in the same case ; and it often becomes a difficult matter to distinguish one from the other. Chronic parenchymatous nephritis is diagnosed on the recognition of a fatty epithelial cell ; the waxy kidney can be diagnosed only in the rarest instances from the urinary sediment alone.

The presence of numerous waxy casts goes a long way to diagnose the waxy kidney ; but it would not be entirely safe to make such a diagnosis without the presence of a tuberculous or syphilitic history and the concommittant enlargement of the liver and the spleen.

The usual course of chronic parenchymatous disease is to end in the death of the patient ; but sometimes the catastrophe is put off by the timely contraction of the kidney. With the appearance of hypertrophy of the left ventricle the secretion of the urine becomes

increased in quantity, and the patient may linger along for some time before dissolution ultimately overtakes him.

Somewhat different from this secondarily contracted kidney is the contracted kidney of chronic interstitial nephritis. As the tubules do not suffer primarily there is no obstruction to the outflow of urine, and partly for this reason, and partly from the presence of hypertrophy of the left heart we obtain the characteristic symptom of polyalbuminuria. No other form of Bright's disease has this symptom, and if in connection with it we find that the disease has had a slow evolution, that the left heart is hypertrophied, the pulse is hard and tense, and there is an albuminuric retinitis the diagnosis of chronic interstitial nephritis is established beyond a doubt. The sediment itself, although presenting specimens of degenerated renal tissue, is not characteristic.

These are the diseases that I believe may justly be grouped under the name of Bright's diseases. Leyden includes also pyelo-nephritis in the group of Bright's diseases, because this disease has albuminuria and dropsy among its symptoms. But he certainly goes beyond the mark set by Bright. The albumin of pyelo-nephritis is cellular albumin wholly, and corresponds in quantity to the amount of pus present in the urine. Moreover, pyelo-nephritis is a focal process of inflammation, while all the diseases of Bright are diffuse renal diseases ; and while pyelo-nephritis usually affects only one kidney, the diseases of Bright always affect both.

The conclusion we reach may be stated as follows : —

1. The diseases of Bright are primary renal diseases ; hence symptoms suggestive of Bright's diseases must be caused by renal disease and not by disease of other organs.
2. The diseases of Bright are all degenerative renal diseases, profoundly affecting the renal structures, and the renal secretion. The degenerated renal tissue is found in the urinary sediment.
3. The diseases of Bright are diffuse renal diseases ; hence pyelonephritis, embolic and other focal diseases should be excluded.
4. The diseases of Bright are bi-renal diseases, which have as their most important symptom the secretion of serum-albumin in the urine.

If we accept the proposition that the diseases of Bright are primary degenerative diffuse bi-renal diseases we shall come to recognize the following diseases as members of this group : —

1. Glomerulo-Nephritis.
2. Acute Parenchymatous Nephritis, with its two varieties : (*a*) catarrhal ; (*b*) hemorrhagic.
3. Chronic Parenchymatous Nephritis.
4. The Waxy Kidney.
5. The Parenchymatous or Secondary Contracted Kidney.
6. Chronic Interstitial Nephritis or Primary Contracted Kidney.

In this cursory study of so great a subject as Bright's disease I may be pardoned for giving only the most essential and characteristic signs of the diseases. Every one knows that a person suffering from renal albuminuria will sooner or later develop dropsy, since when the kidneys are embarrassed in their natural function of separating the water from the blood some water will be retained in the body. A quick way of distinguishing renal dropsy from cardiac dropsy is to note the appearance of the skin. Pallor speaks for renal origin, cyanosis for cardiac origin. Everyone knows, also, that the urinary secretion cannot be interrupted for any length of time without causing uræmic symptoms. But it is clear that both dropsy and uræmia are consequences of albuminuria, and no introduction can be presented to the consideration of the prophylaxis and the treatment of Bright's diseases without laying an especial stress upon the symptomatology and the composition of the urine.

CAUSES AND PROPHYLAXIS IN CHRONIC NEPHRITIS.

JOHN J. SHAW, M. D.

In this paper, for which I am about to crave your forbearance, it is not my intention or expectation to instruct you, nor do I expect to present you with any facts with which you are not already acquainted. But I do hope to stimulate thought and discussion, for by such means alone can truth be established.

It is an old saying that "an ounce of prevention is worth a pound of cure." If this is true in cases where the pound of cure is effective in bringing about a state of health, how much more important becomes the ounce of prevention in cases like chronic nephritis, where any number of pounds of cure having been expended we only succeed like the Irish doctor, in curing our patient until they die.

The number of persons who die of Bright's disease is large and apparently increasing. How many times in our own experience has some case of an apparently robust person to whom we have been called for the treatment of some supposedly unimportant ailment, been found on careful investigation to be a case of chronic nephritis, and the existing conditions, such as to show that the morbid process must have been going on for months, and the conditions leading up to it, for perhaps years. So insidious is its approach that thus oftentimes when our attention is called to the matter the process of disorganization has reached that point where, without a miracle, restoration is impossible. How important it then becomes that we should instruct the people in those hygienic means by which they may avoid this dreaded disease.

It has been said that the first stages of disease in any organ, are but nature's healthy activities exaggerated. Accepting this as true let us apply it to the matter in hand. To pass pure water through the kidney does not require any expenditure of vital force, since the structure of the kidney is such that it permits it to pass freely. Since then no vital action is required there can be no exaggerated action, even if the quantity passed through is very large, and hence it cannot set up diseased action. On the contrary, water being the universal solvent its passage through the kidney is salutary since it dissolves and washes away deleterious substances. Free water drinking is therefore the first requisite of healthy kidneys. But unfortunately, water-drinkers are in the habit of requiring their drinking-water to be at a temperature of about 32°, or at about the freezing point of water. When we consider that the temperature of the human body is 98.6°, or over 66° higher, we can see that the shock to the system when taken in considerable quantities, as it generally is in hot weather, must necessarily be severe.

The effect of such sudden and severe cooling, is to produce reaction and the kidneys and other vital organs are congested with blood which the vital force throws into them in an endeavor to keep up the normal temperature. This condition, by continual repetition of the irritating cause, becomes chronic, and it is but one step further to chronic inflammation. I believe this to be one of the potent causes of Bright's disease among the temperance classes.

Again, alcohol is a substance, which, when taken into the system is eliminated largely through the kidneys, but not being normal to these organs it is an irritant. Irritation causes congestion. If this irritation is only occasionally applied there is healthy reaction and relief, but, if the irritant be constantly applied, the congestion becomes an established condition and the first stage of chronic inflammation is produced. Therefore it is that beer drinkers furnish such a large per centage of cases of Bright's disease; and all regular drinkers of alcoholic beverages are in danger.

The excessive eating of meat, especially beef and pork, which is practiced very extensively in this country, is another prolific source of Bright's disease.

These foods supply such a large per centage of nitrogenous matter that the liver is unable to complete its oxidation and in consequence there is produced uric acid which is quite insoluble, instead of urea which is perfectly so, and which is therefore normal to the kidney and can be excreted by them in large quantities.

Uric or lithic acid is a violent irritant to the kidneys and it often also gives rise to the formation of concretions there, which interfere in the performance of their functions and still further give rise to local congestion and inflammation. And thus again we have the first stages of Bright's disease.

Although the nitrogenous foods are especially harmful, overloading the digestive organs with food of any kind may lead to the same result. Especially is this true when the occupation is sedentary, for under such circumstances not the digestives only do their work more imperfectly, but the liver is especially sluggish in its action, and the production of the much-dreaded lithic acid is particularly favored.

Again we take note that the skin is a depurative organ, but if it does not do the work which belongs to it the kidneys must take much of the burden. The necessity of dress, which is upon us in this inclement country of ours, is a constant obstacle to the skin's performing its proper functions, and we are necessarily in a dilemma as to how we shall dress most healthfully. The general opinion has been that the all important need was to keep the surface warm. Hence we see the heavy woolen under garments which hopelessly handicap the skin as an eliminating organ.

Women as a rule do not wear as much clothing by one half as do men, but more men die of Bright's disease than women. Close fitting woolen garments should never be worn next the skin by people who spend much of their time indoors. Silk, linen or cotton are best in the order named. Allow the skin to be properly ventilated and put the woolen on outside if needed for warmth.

Last, but not least, in predisposing to Bright's disease, I will mention lack of sufficient exercise. This leads to imperfect action of all the organs, and the consequence is the whole system is clogged up with effete material which cannot be gotten rid of and which consequently sets up local irritation, congestion and inflammation.

There are undoubtedly many other minor causes of Bright's disease, but these I believe to be the most important and I will recapitulate them in the order of their supposed importance.

1. Over-eating, especially of nitrogenous foods.
2. Insufficient exercise.
3. The regular habit of taking alcoholic beverages.
4. The free drinking of ice-water.
5. Bad dressing as affecting the healthy action of the skin.

If we instruct our patrons in these five points and they will act upon our warning, I am sure we shall prevent many cases of this dread disease.

PHOSPHORIC ACID IN THE URINE; ITS SOURCES, AND QUANTITATIVE ESTIMATION.

F. P. BATCHELDER, M. D.

Tests for phosphates in the urine have been made by clinicians for decades, but the actual knowledge acquired thereby has been of little value. Such tests, of necessity, give us only a general idea of the phosphates present in a given sample of urine, but no accurate knowledge of the work done by the kidneys in a specified time.

Under the title of "Two Urological Myths," the esteemed editor of the North American Journal of Homeopathy, Dr. Eugene H. Porter, has most aptly stated the situation and shown the utter unreliability of the usual precipitation methods in determining the actual amount of phosphates in the twenty-four hours urine. (See N. A. Jour. Hom., Feb. '98.)

It is the object of the present paper to state a few of the known facts pertaining to the sources and elimination of combined phosphoric acid, as found in the urine, to speak of the only reliable method of determining the amount of the same, and show by a few examples the practical application of this method in the study and treatment of our cases.

Sources of Phosphoric Acid. Ultimately all can be traced to combined phosphoric acid in the food ingested, occurring as the phosphates of the alkalis and alkaline earths, with a smaller proportion organically combined in nuclein, casein, etc.

In the body structure we find it present in all tissues and essential to functional activity. The phosphates are an essential part of the proteid molecule, and protoplasmic activity is followed by more or less elimination of inorganic phosphates.

A considerable portion of the phosphates occurs in the circulating media of the body, the blood and lymph. There are thus two paths which the phosphates travel, one via the body tissues, and the other where they pass from the digestive tract via the blood stream to the renal tissues direct. This is similar to the course taken by the proteid food ingested, and throws light on the average ratio of urea to phosphoric acid in the urine, and the marked dependence of an increase or decrease of either, in a state of health, upon variations in the food ingested, particularly of proteid foods.

Without speaking of data in detail along this line let us bear in mind that phosphoric acid of the urine occurs as the acid phosphate of sodium, (Na H 2 Po 4) to which the urine largely owes its acid reaction, potassium phosphate, (K H 2 Po 4) calcuic and magnesian phosphates.

Since these differ somewhat from their antecedents in the blood of the renal artery, such change seems dependent upon functional activity of the glomerular epithelium. All physiological evidence of a satisfactory character goes to show that the epithelium of the glomeruli, rather than of the tubules, takes an active part in the elimination of the phosphates and other inorganic salts, and that such elimination is not effected by a process of filtration solely.

The amount of phosphoric acid eliminated in the urine of a healthy individual in twenty-four hours is said to average from 2.5 to 3.5 grammes, (Parkes), according to sex, diet, etc. In the person of the celebrated E. A. Parkes of London, we note an indefatigable worker and observer of "the urine in health and disease," and in his book

bearing that title, and published in 1860 will be found many data which hold good today.

Quantitative Estimation of Phosphoric Acid. This is accomplished by titration, a process familiar to all students of analytical chemistry. For this, three solutions are necessary.

1. A solution of uranium nitrate standardized so that 20. cc. of the solution shall correspond to 0.1 gramme of phosphoric acid.
2. *Sodium acetate solution.* Containing

Sodium acetate	100 grammes,
Acetic acid (36 %)	100 cc.
Distilled water	900 cc.

3. Solution of Potassium ferrocyanide, for use as an indicator. Some recommend a 5 per cent. solution in distilled water, while others adopt a saturated solution.

The apparatus necessary consists of the iron stand used by chemists, a burette graduated to 0.1 cc. and having a capacity of 50 cc., a water bath and beaker glass, glass rod. Bunsen burner or alcohol lamp, and some white dishes or a white plate.

The burette is filled to the O mark with the uranium solution, and adjusted in position.

Fifty cc. of clear filtered urine are placed in the beaker or tumbler and 5 cc. of the sodium acetate solution added. Heat till the water in bath boils. Place several drops of the potassium ferrocyanide solution separately on the plate or in dishes. The uranium solution is then run into the contents of beaker cautiously. The sp. gr. of the urine is a rough guide as to how much will be required. In urine of 1015 sp. gr. it is well to run in 8 to 10 cc. of the uranium solution, and stir well with glass rod or tube. Put a small drop of this in contact with a drop of the ferro cyanide solution. If no change in color results add more uranium solution cautiously, and test as before. Stop when a very slight reddish color becomes manifest, which indicates the end reaction. For details as to the carrying out of the test and computation of results, see any of the recent works on urinalysis, (Purdy or Mitchell). A simple rule is as follows: If for example 18 cc. of uranium solution were used, move the decimal point one place to the left. So 1.8 grams of phosphoric acid are present in 1000 cc. of the urine. Multiply this by the actual twenty-four hours amount of the mixed urine in cc.

The process is simple to execute, and requires but a few moments for completion; in fact it is nearly as simple to make as the urea test by the hypobromite method.

One unfamiliar with the process described might well ask, "of what practical value is this?"

Time will not permit the enumeration of the numerous pathological conditions in which the phosphoric acid of the urine is either increased or decreased.

Let us choose a single disease, nephritis. The urea test is of great value here, and when supplemented by the data derived from estimation of the phosphoric acid will enable us to know our cases better, and treat them more intelligently.

Surely every one will admit that three points in evidence are more trustworthy than one or two.

With a sample of urine taken from the mixed and measured twenty-four hours' urine, tested both for urea and phosphoric acid, we can know with a reasonable degree of accuracy just how well the kidneys are performing their work, and render a prognosis accordingly.

The following instance aptly illustrates the value of the determination of phosphoric acid and urea.

The sample from the mixed and measured twenty-four hours urine was submitted by the patient's physician, Dr. Frederick A. Davis.

Examination showed

24 hours' amount of urine 56% of normal average
" " " " urea 24% " " "
" " " " phosphoric acid 12% of normal average

or about 0.31 gramme.

The amount of albumin present showed only a slight precipitate by the heat or Esbach's tests.

Large numbers of granular casts were present.

In view of the very marked renal insufficiency, an unfavorable prognosis was given, which was based in part on the low % of phosphoric acid and urea eliminated. The patient lived only four days after the analysis was made.

A fragment of the experience of Prof. Clifford Mitchell of Chicago may be stated in his own words. "In the majority of fifty-three fatal cases of Bright's disease, the total quantity of phosphoric acid per twenty-four hours was found to be less than 1.5 grammes." "Less than 1 gramme was found in 33% of the analyses."

In summarizing his experience in 1895, he wrote as follows: —

"Twice as many people live as die of those having albuminuria with granular, or fatty or waxy casts when at the same time they void more than 1.5 gramme of phosphoric acid in twenty-four hours. On the other hand, three times as many people die as live when in addition to albuminuria with granular or fatty or waxy casts they void less than 1 gramme of phosphoric acid in twenty-four hours."

The continued accumulation of evidence shows that the estimation of the twenty-four hours elimination of phosphoric acid is a valuable factor in the prognosis of renal and other diseases.

DISCUSSION.

Dr. E. P. Colby said he had listened with pleasure and instruction to this paper of Dr. Batchelder, as he always expected to do when the Doctor furnished a paper. The subject matter of the essay was of

vast importance in many respects both as to treatment and prognosis in many cases of so-called renal insufficiency. A serious question sometimes arises whether this trouble is wholly or chiefly due to renal insufficiency, or is the insufficiency only a part, and a minor part at that, of the trouble which results so disastrously in many instances. He did not see how an answer could be given from our present methods of investigation, which would have to be amplified very materially before we could decide whether the process was an accumulation of morbid results, or whether it was, to a greater or less extent, a particular diseased condition, or a disturbance in metabolism, and under changes which go on through life, and which, by an incomplete process, develops a poison which acts upon the whole system but more particularly upon the blood and nervous system. In other words we know that a large percentage of phosphoric acid comes from nuclein metabolism and there is, perhaps, no more active manufactory of toxines in the system than a disordered nuclein metabolism. Is the diminution of phosphoric acid then one which can be gone at on account of insufficieney of the kidneys, the result of pathological conditions, or a change in metabolism resulting in a toxic condition, a development of toxines, in other words. He hoped Dr. Batchelder would have the time and opportunity to investigate further in this direction, and he would suggest at the same time a more extended examination of the condition of the blood, in order to know whether there is, in these cases, an accumulation in the blood of phosphoric acid in the form of various phosphates. If nuclein metabolism or other sources of phosphoric acid is going on in the normal way, and the condition comes from renal insufficiency, then as a result we must get a damming up in the fluids of the body, not relieved through the kidneys. On the other hand, if the condition is due to an error in the metabolism then we would not have this particular damming up but a development of toxines. He trusted that Dr. Batchelder would have the means at his disposal to answer this question, and when he had done so he felt sure that he would add very greatly to the interesting subject given to-day.

REPORT OF AN UNUSUAL CASE.

D. W. VAN DER BURGH, M. D., FALL RIVER, MASS.

Mrs. A——, aged seventy-four to seventy-five, large and fleshy, full appetite, arthritic tendency, dropsy of the lower limbs, shortness of breath, asthmatic and necessarily very little exercise, sleepiness in daytime, forgetfulness and dullness of intellect, was taken at about 8 P. M. on February 10, 1898, with sharp pains in right side of abdomen, radiating from the umbilical region, intermittent in character, vomiting, pulse full, 78, which had been before feeble and slow, 66,

temperature 99.2°. Prescribed coloc. 6 x and diosc. 1 x at frequent intervals.

February 11, 8 A. M. Temperature 98.6°, pulse 100, tenderness and hardness of bowels, pains sharp and shooting, whitish coating on broad, thick tongue, vomiting, thirst, impossible to bear pressure on abdomen, urine ʒ v sp. gr. 1000. Prescribed bry. 6 x, high enema, hot poultices to abdomen. Night temperature 98°, pulse 100, respiration 32, urine ʒ vj, sp. gr. 1020, breathing heavy and labored, abdomen distended, vomiting.

February 12. Morning temperature 98°, pulse 100, respiration 30, two hard stools following enema, some gas passed before enema.

February 12, night. Consultation. Breathing labored, patient not so restless, but very thirsty, abdomen still very tender, and distension on right side marked, feeling as of a tumor. Diagnosis, obstruction of bowels, probably intussusception. Better, night, temperature 98°, pulse 96, respiration 30. Prescribed opium 4 x, nux vom. 3 x.

February 13. Temperature 99°, pulse 100, respiration 34. Resting more quietly, three stools, one large and fecal, two yellow and watery. Night very restless, little sleep—three quarters of an hour—excessive thirst.

February 14. Temperature 99°, pulse 100, respiration 34. Fair day, slept some, breathing oppressed, two liquid stools, light colored. Night temperature 100°, pulse 100, respiration 36; complains of being "so very tired," four very watery, light-colored stools. Rested some first part of night, no sleep latter part, thirst not so severe.

February 15. Temperature 99.2°, pulse 100, respiration 36. Coughs considerable, dry, hard and spasmodic, tongue not quite so coated, thick and flabby, aggravation of all symptoms at night, one liquid stool. Prescribed merc. sol. 6 x. Night temperature 101.8°, pulse 112, respiration 30. Later temperature 101.2°, pulse 102.

February 16. Temperature, 99.8°, pulse 100, respiration 30, 7 A. M. Temperature 101°, 4 P. M. Temperature 101°, pulse 112, respiration 30, 6 P. M. Night temperature 99.5°, pulse, 99; four stools, small and loose.

February 17. Temperature 98.6°, pulse 90, respiration 27; four stools.

February 18. Temperature 99.4°, pulse 84, respiration 30; some improvement. Night temperature 100°, pulse 94; five small, loose stools.

February 19. Temperature 99°, pulse 82; four small, yellow, loose stools; tongue red.

February 20. Temperature 99°, pulse 80, respiration 30; five loose stools; tenesmus.

February 21. Temperature 99°, pulse 74, respiration 30; one stool quite formed, patient restless. Night temperature 99°, pulse 82, respiration 32.

February 22. Temperature 99°, pulse 74, respiration 32. Night temperature 100°, pulse 82. Sat up 15 minutes.

February 23. Temperature 98.6°, pulse 72. Night temperature 100.6°, pulse 90; some improvement.

February 24. Temperature 98°, pulse 72. Night temperature 100.6°, pulse 90; four stools.

February 25. Temperature 98.6°, pulse 72. Night temperature 100° pulse 82; two stools.

February 26. Temperature 98.6°, pulse 66. Night temperature 100°, pulse 80; two stools very loose.

February 27. Temperature 99.4°, pulse 80. Night temperature 100°, pulse 82; vomited some curd; two stools formed.

February 28. Temperature 98.6 , pulse 72. Night temperature 98.8°, pulse 72; sleeping very little, constantly changing positions; frequent desire to urinate without ability; one small, loose stool.

February 29. Temperature 98°, pulse 72; passed in P. M. fourteen inches of small intestine, extremely weak afterward.

The case has continued to improve since. The nourishment throughout has been malted milk and beef peptonoids, junket and such light liquid food.

REPORT OF THE COMMITTEE ON OBSTETRICS.

I. A Case of Puerperal Septicemia. S. M. Perkins, M. D.
II. The Work of the Maternity Department of the Dispensary.
George H. Earl, M. D.

A CASE OF PUERPERAL SEPTICEMIA.

STELLA MANNING PERKINS, M. D., LYNN, MASS.

This case which I present is one where the physician is liable to be led into serious error by the false statements of the patient.

On Thursday afternoon, November 4, 1897, I received an order to call on Mrs. F., the messenger saying she had a bad diarrhœa, and would like to have me come as soon as office hours were over. This I did, and found the patient, a stranger, apparently very ill. She was in bed, pale, thin, anæmic in appearance, and very nervous.

As I came into the room she vomited a little brandy and water which she had just taken. By inquiry I found she had been unable to retain anything on the stomach that day, and had had several loose movements of the bowels during the previous night. Since noon the bowels had averaged to move once an hour. Pulse 130. Temperature 103.2°.

The bowels showed slight tenderness on pressure over the region of the uterus. Questioning her in regard to her menstruation, she said she was all right, had just recovered from her period when this sickness began, a week before.

Feeling that there must be some uterine disturbance, I enquired again about the last period, whether she had pain, flowed as much or more than usual, passed clots, etc. To this she said she had some pain, not much, flowed as usual, had no clots, since that time had noticed some leucorrhœa.

I prescribed Bell. and Arsen., and said I would call in the morning.

November 5. Called early. Patient had slept some. Pulse, 120. Temperature 101.6°. Vomiting had ceased.

Anxious husband wanted to know what I thought of the case. I said she was very sick, and had all the appearance of septic poisoning. Tried to get some history of the case from him. He said she had not miscarried, and that the diarrhœa must be due to something she had eaten. In the course of conversation he remarked that it was just two weeks the day before since she was taken sick. This did not correspond with the previous statement of Mrs. F., who told me when I called first that she had been sick a week.

After cleansing the genital tract and using a carbolized douche, I made a uterine examination. The os was quite firmly closed, causing some difficulty in passing the sound. The uterus was slightly enlarged sensitive to touch, and apparently empty.

I now felt sure this was the seat of the trouble. The general appearance of the patient, the conflicting statements as to how long she had been ill, the positive denial of the possibility of miscarriage in the presence of conditions indicating that it had occurred, convinced me that it was a case of puerperal septicemia.

She had a very competent nurse, and I ordered a carbolized douche every six hours, and a close watch for any shreds or fragments of placental tissue. Continued bell. and arsen. Gave diet of malted milk and port wine. When I called that night, she complained of the wine burning in her stomach, and was obliged to give up taking it.

The stomach being still unable to tolerate any stimulant, I ordered panopepton and iced milk, which were well borne. Pulse 120 A. M., 128 P. M. Temperature 102.6° A. M., 102° P. M.

Saturday, November 6. Patient more comfortable. The douches were continued through the day every six hours. Condition of patient unchanged.

Sunday and Monday the pulse ranged from 118 to 124. Temperature, 102.4° to 102.9°.

Monday evening she had slight pain in the uterus, relieved by the douche.

On Tuesday morning the nurse showed me some shreds of placenta, which had washed out the evening before. Believing there might be more where this came from, I determined to dilate, and remove if any were found.

Dr. Varney was called and gave the ether. The internal os was quite firmly closed, but yielded to Palmer's dilator. On removing the dilator, the cervix contracted, internal os closing so that nothing larger than a sound would pass.

After dilating several times and being unable to insert the finger, I inserted a small, dull spoon curette, and removed altogether something more than a teaspoonful of detritus. After this the uterine cavity was thoroughly douched with hydrogen dioxide.

Wednesday morning the temperature rose to 102.5°. Pulse 132. There was increased tenderness over the region of the uterus, chills,

and pain in the right iliac region. Prescribed Chin. Ars. 2 x and bell 3 x.

The next three days showed marked metritis, abdominal distention, circumscribed peritonitis, with pelvic exudate. Uterus fixed and immovable. Applied thin flax-seed poultices to abdomen, covering them with oiled silk. These afforded some comfort. The diarrhœa, which had abated, now returned.

On Sunday morning the temperature was 103.5°, pulse 130 and weak. The case looked very unpromising. Dr. George R. Southwick was called in consultation. After examining the case he said the patient could be more suitably treated in a hospital than at home. There being no homeopathic hospital nearer than Boston, and she being too ill to be carried there, we resolved to do the best we could under the circumstances.

He advised the application of the cold coil to the abdomen, champagne every twenty minutes, two teaspoonfuls. Rhus. and arsen., internally. To assist in controlling the diarrhœa a gruel made from grated flour ball was ordered.

It being Sunday there was some delay in securing a sufficient quantity of small rubber tubing for our purpose. By nine o'clock in the evening the coil was in working order.

The pipe was attached to the cold water faucet in the bathroom, carried across the hall to her chamber, made an oval coil well covering the abdomen, and returning to the bathroom emptied into the bath tub.

Two thicknesses of cotton cloth were placed under the coil, and a hot water bag at her feet, and the water turned on.

With the exception of fifteen minutes, when the coupling of the pipes gave out, this coil of cold running water was applied continuously for twenty-six hours. At the end of the first hour she experienced great relief and fell asleep.

She was carefully watched, and her temperature taken frequently. The coil was to be removed when the temperature reached normal, but by some oversight it stayed on until one degree subnormal was reached. On removal the temperature rose to 101°, and the coil was replaced.

During the next twenty-four hours the coil was applied twenty minutes out of each hour. From that time the patient improved, but the coil was used more or less each day during the following week. As soon as the temperature was reduced the appetite improved, diarrhœa abated, and the patient began to rally. The champagne was continued with lengthening intervals during the following two weeks. A highly nourishing diet was given. By degrees the tenderness disappeared from the bowels. The exudate slowly absorbed. On this account the patient was kept in the recumbent position after her general strength would have allowed her to sit up.

On December 5, menstruation appeared, accompanied by pain in

the right iliac region. At this time also occurred a mild attack of pleurisy, lasting only a few days.

From this time convalescence was rapid and satisfactory. On January tenth menstruation appeared again. At this time the patient was moving about, doing some light housework. During this period the same pain appeared in the right iliac region, and later examination showed the right ovary and tube bound by adhesions. Otherwise than this she had fully recovered.

Toward the last of January she went away from the coast for two weeks. On her return she said she had never felt so well in her life.

THE WORK OF THE MATERNITY DEPARTMENT OF THE DISPENSARY.

GEO. H. EARL, M. D.

During the five years, from 1893 to 1897 inclusive, upwards of thirteen hundred women have been attended in confinement from the maternity department of the Dispensary on Harrison Avenue.

The number in each year was : —

1893	212
1894	218
1895	207
1896	336
1897	351
	1,324 total.
1898, First Quarter .	101

No attempt has been made to compile and arrange statistics from this mass of material, but a somewhat definite policy and plan of treatment has been followed, and the results have been such as to convince me that we have started on the right road.

Less than two decades ago the physician who used a post partum douche, containing carbolic acid, was considered quite up-to-date. He washed his hands after a vaginal examination, but not before making one.

The writer can remember the rise and fall of the bi-chloride of mercury craze, in obstetrics. Fortunately it was short-lived, but it lasted long enough to cause the death of several hundred women.

Our plan has been to make the hands of the attendants and the external genitals of the woman as clean as they can be made by the use of soap and water, and the avoidance of all poisonous antiseptics.

Of the results you may judge, but first let me describe to you the

general plan under which the work is carried on, and the modifications of the above general plan for special cases.

Two members of the senior class from the medical school are on obstetric duty at a time, and remain in the dispensary building night and day, for one week attending all cases which come.

Formerly the students were left to themselves with many of the normal cases, sending for the instructor, however, in all cases of uncertainty or difficulty.

During the present season, in accordance with a plan, long under consideration, an instructor has been present at nearly every case, and in no instance has a student been sent to his first case alone, *i. e.*, without an instructor.

In addition, members of the junior class attend these cases in turn, as assistants. Thus the students have opportunity to witness cases, while receiving instruction in normal obstetrics, and actually attend cases during the senior year while receiving instruction in abnormal and operative obstetrics.

The question of asepsis has been given great prominence in the clinical teaching, and the broad stand taken, that thorough cleanliness is the one and only thing necessary in normal cases. That antisepsis was only a means to an end, and that the end desired was asepsis. The one object in view in the present sketch is to throw what light we may on the question of infection and non infection in child-bed. Vaginal examinations have been restricted. Special emphasis has been laid upon the value of external examination, *i. e.*, palpation, as a means of diagnosis and prognosis in all stages of labor.

The use of non-toxic antiseptics when any were used, as for instance permanganate of potash in douches, and per oxide of hydrogen when sepsis was to be dealt with.

The students have been told that the chief danger of infection for a lying in woman, is from the fingers of the attendant.

A woman in labor is first examined carefully and deliberately by external palpation. Effort is made to ascertain the presentation, the adaptability between the presenting part and the pelvis, the location of the placenta, etc. Before a vaginal examination is made the external genitals are washed with soap and water, and the hands thoroughly scrubbed.

An ante-partum vaginal douche is only given in the presence of foul discharge, and then it is not only douched, but washed with soap and water and gauze, and this followed by swabbing with per oxide of of hydrogen.

The ground is taken that the natural secretions and an intact mucous membrane best protect the woman.

Vaginal examinations are restricted to one, until some special indication is seen for another.

No post partum vaginal interference is allowed in normal cases.

In case of adherent placenta the hand is further sterilized by the use of alcohol, and another scrubbing, but no post partum douche is given.

The effort is made to avoid introducing infection, rather than to destroy what may be there.

This is advanced ground, but in the five years we have had only five maternal deaths.

Three of these were cases of eclampsia, and two of those died after removal to the City hospital.

The other two died of sepsis, and one of these was in an advanced stage of pulmonary consumption.

Poisonous antiseptic solutions are ruled out, and as far as possible the use of apparatus. A septic abortion in which it is necessary to cleanse the uterine cavity, for instance, is treated as follows : —

The external genitals and vagina are cleansed with soap and water, and gauze, then the vagina with H. 2. O. 2, and dried with gauze. Then the cavity wiped out with clean gauze ; then curretted, again dried, swabbed with H. 2 O. 2, dried again, and drained with gauze.

Many cases treated in this way require no further local treatment, the temperature falling in a few hours to normal, and remaining so without even the necessity of a vaginal douche. Cases like the following are not infrequent : —

A woman, three to five days after delivery, has a chill and rise of temperature to 103 or 104. She has headache, coated tongue, thirst and loss of appetite. No local evidences of sepsis, *i. e.*, no unhealthy appearance of abrasions, no tenderness of the uterus. Inquiry elicits the fact that there has been no movement of the bowels, and soap and water again is brought into play with the most happy results, the whole aspect changing to a normal one in a few hours.

It has been found that a laceration of the perineum may be repaired twenty-four or forty-eight hours after occurrence with healing. It is the practice to remove stitches in four or five days.

Silk worm gut only is used, and the sutures are removed thus early for the following reason : —

If the wound is clean at the time of repair, and is kept so for twenty-four hours, it has united.

After three or four days, the lochia consists of broken down material, which unavoidably comes in contact with the sutures. The sutures have begun to cut a little in the skin, making entrance of the lochia possible, infection easily follows, and the healing is undone.

Women are allowed to sit up as soon as they feel like it, anywhere from three or four, to occasionally as long as ten or twelve days.

They are urged to urinate from the first in a sitting position, for the purpose of favoring uterine and vaginal drainage.

DISCUSSION.

Dr. Southwick said that all of us had had trouble with cases coming for treatment late and with obscure histories. He had recently a case of severe dysmenorrhœa, and it was apparently a trouble of that kind, but later results showed that it was the same old story, a retained placenta. It was most unfortunate that we were so often handicapped by statements of patients not absolutely true. When in making an examination we found a round uterus instead of a flat one we had the right to be suspicious, and it might not be advisable to look for further reasons as a cause. Again in cases even of correct history it was often difficult to tell whether it is a straight case of infection or an attack of malaria. One thing would help materially in making the diagnosis, and that was, that in puerperal infection there was no alteration in the constituents of the blood as there was in malaria. The treatment employed in the case reported by Dr. Perkins, brings up the old question whether to use the curette or not. It is a question not settled and still has its advocates, friends and enemies. He was not ready to give up the curette, although even when used carefully it might break down the protecting wall lining the uterine cavity, and allow the bacterial invasion of the system and a general infection follow. The result not much better when we use the finger, although its use is preferable when it can be done. We often see cases where we cannot open the os even after considerable force in the use of the dilator without giving rise to traumatism, and then we have to consider the use of the dry treatment, or the gauze tampon in wiping out the uterus. He did not think, however, that the uterus could be thoroughly cleansed by this method. In one case of abortion that he had seen, the retained piece of placenta was not larger than an English walnut, but the uterus in contracting had come down upon this piece of tissue and it was retained at a level with the uterine walls, embedded in the wall, in fact. A curette would hardly have dislodged it except with the most careful use. He thought there were cases where the finger had to be used, and on the other hand, where the curette was the only resort, as the time had not come yet when we could decide exclusively for or against either method. In regard to cold he had seen it used repeatedly with the best results, especially in pelvic cellulitis with exudation. These cases are very prone to suppuration and are often accompanied with salpingitis or other severe complications, binding down uterus, ovaries and tubes, and giving rise to conditions from which recovery is difficult. It is in these cases that the use of cold is a most important factor, retarding suppuration. He had seen icebags used in cases of large exudate into pelvic cavity, and the uterus fixed in a solid mass, with most gratifying results, the large masses of exudate disappearing or absorbing, and the patient go on to a reasonable good recovery. Suppuration once begun the application of cold may

tend to limit, but cannot, of course, prevent. Hoped something migh tbe suggested as to remedies, he used rhus tox. most frequently, arsenicum less often, secale two or three times. He thought that alcohol in some form or other was not used as much as it ought to be. There were times when alcohol helped metabolism and materially prevented the waste which would otherwise take place. It was an important agent when carefully used. It was possible that cold was used to prevent more than it ought to be.

Dr. Powers said it was a query in his mind, while listening to the reading of the paper, whether, if the curette was to be used, it would not have been wiser to have used it about three days earlier than it was done. This was the time, he thought, rather than after the uterine wall was affected. The history of this case was misleading, no doubt, but the point he wanted to make was, that granted the choice of time, whether the earlier period would not be the one to take with the greater possibility of benefit.

Dr. Newton desired to say a word in regard to the use of hydrogen dioxide and the uterine douche. He thought the former should only be used when we were sure that we had a free return from the uterus, and if we found we did not have this the cathether should be withdrawn until we know that the conditions are favorable. The effervescence of the dioxide with possible dilatation of the tubes would lead to the question whether it might not do more harm than good. As to the examination of the blood we might have both conditions present in the same patient. It might be a question whether it was a greater danger to wait than to attack the uterine cavity at once. If the examination of the cavity was attended with some danger and we wanted to avoid that it might be justifiable to wait. He remembered being taught that it was dangerous to make a digital examination in some of these cases, but with the better way of doing it to-day the danger does not exist to the same degree, if at all. It is necessary to find out as promptly as possible what condition is present, and act upon it as soon as possible, in order to save valuable time.

Dr. Earl said that he had seen a large number of septic cases due to abortion, in the Dispensary and private practice, and he had never seen a case of septic uterus after abortion which would not admit the little finger at least. With all due respect to the writer he still thought the case was one of pelvic inflammation and that the uterus was never septic at any time. Almost any uterus would show a teaspoonful of some form of discharge if curetted.

Dr. Boothby felt like agreeing with Dr. Earl in the diagnosis of this case, as the history and its active symptoms indicated an affection

other than that arising from abortion, and it seemed to him to be, from the first, a pelvic peritonitis. The curette did not settle the question in this case unless we had a clear knowledge that it was the uterine edometrium that was scraped away, for you will find a certain quantity of debris in many cases. In regard to the early use of the curette, if it was to be used while the system was in a progressive stage, he thought it better not to use it. The time might come when something had to be done at once, but we ought to be as sure of its necessity as possible. If the case was not due to abortion but depended upon something else as a cause, then the curette was not advisable at any stage. In every case of abortion seen by him where curettement was done the temperature and pulse fell immediately, for a time at least, and the cases were almost always favorable if the operation had been thorough and the uterine cavity thoroughly cleansed. He should certainly agree with a previous speaker that there might be danger in using hydrogen dioxide in the condition as described. Cleansing should certainly be done under very thorough dilatation and a return flow. He would cleanse very thoroughly with water in such cases, letting it run in and out for ten minutes at least, and use then some antiseptic. If you were having progressive inflammation you would not leave anything on the surface to be absorbed, and you would cure your patient by easier methods.

Dr. Rand hardly thought there was very much risk in the use of the hydrogen with a double catheter, as the return back flow offered an easier passage than into the tubes. He believed in the use of cold in any acute inflammation, or where acute suppuration was threatening. We were all acquainted with the action of heat upon yeast in the domestic economy, and he felt certain that the use of heat in many of these conditions only served the better to develop microbic action.

Dr. Newton said in regard to the use of the return catheter that we should bear in mind not to wash out the uterine cavity unless we were certain that the flow would come back, it was not like washing out the bladder. The tube should pass in and out readily and some of the flow should continue to run out even when the tube had been removed. Otherwise you have an excess of bubbles of gas, which if not necessarily dangerous are no additional benefit. Water will itself wash out debris very well. Thorough curettement causes hemorrhage and we should give this free exit with thorough dilatation and free return.

Dr. Southwick said as to diagnosis that he did not see the case in the beginning when curetted, but the doctor had told him that she had seen placental fragments, and he felt perfectly confident that it was so. He had seen similar cases frequently. You can perhaps carry dilatation to a certain point, but after that, if you persist, you are

likely to split it open. They may be exceptional cases, but they do exist. The point made as to the use of hydrogen was a good one, but he did not think that was the way to employ it, using so strong a mixture. He preferred to apply it on gauze wrapped around a pair of dressing forceps with long slender blades, and with this thoroughly cleanse the uterine cavity by wiping. As to the douche, you should thoroughly wash out the cavity before using the curette, and thus do away with all septic matter before you make a raw surface. A very good curette is one known as the douching curette. It was of course essential to thoroughly wash out after its use, and even after this it was advisable to wipe out the uterus with gauze, especially if the case was septic. This was preferable to the use of bichloride, to which some patients are very susceptible. Besides this agent did not penetrate the tissues, but formed an albuminate, which was insoluble. If used it should have added to it tartaric acid, which prevented this chemical combination. Another valuable agent was lyssol, which he considered very much better than carbolic acid, and was safer than corrosive sublimate.

REPORT OF COMMITTEE ON INSANITY AND NERVOUS DISEASES.

I. Neurasthenia. J. Francis Bothfeld, M. D.
II. A Paper. Geo. S. Adams, M. D.
III. Further Report on the Beneficial Effect of Galvanism in Spinal Sclerosis. Frank C. Richardson, M. D.

THE RE-ESTABLISHMENT OF NORMAL INTESTINAL DIGESTION, AN IMPORTANT FACTOR IN THE TREATMENT OF NEURASTHENIA.

JAMES F. BOTHFELD, M. D., NEWTON, MASS.

Since the reading of a brief paper on "The Mucous Colitis of Neurasthenia" a year ago, and its publication in the September 1897 number of the *New England Medical Gazette*, I have received so many inquiries and communications from other physicians on this subject that it occurred to me that another short note on a similar topic might not be out of place.

A year ago my effort was to call attention to the frequent association of a mucous colitis with the neurasthenic state. No claim of priority of observation on this "pseudo-membranous enteritis" was intended, only its unusually frequent association with "nervous prostration" was urged, a fact which text books on Nervous Diseases had here-to-fore failed to notice. Dr. R. Ludlam of Chicago, kindly called my attention to an article on Mucous Colitis by Dr. E. Monod published in the *Annales de la Polyclinique de Bordeaux*, but as that article simply demonstrated the occurrence of this condition in gynæcological diseases, it had no particular bearing on my former paper. More recently, Dana in the fourth edition of his work on Nervous Diseases, has taken up the subject, and in less than a page reviews our present knowledge of it, closing with the statement that "mucous enteritis sometimes occurs in persons who are profoundly asthenic without any decided neurasthenia, yet, in the great majority of cases, it is a symptom of neurasthenia, and can be successfully treated only on such a basis."

In a case of Neurasthenia with marked intestinal indigestion it is certainly an unsettled question to what extent the nervous symptoms are caused by improper absorption and metabolism, by antotoxæmia, etc. Many cases of nervous exhaustion are preceeded by long periods of digestive disturbances, and I have repeatedly observed long standing cases of neurasthenia markedly improve when a successful effort had been made to improve digestion. The intestines are usually more at fault than the stomach, and I claim that along with the "rest treatment" our chief aim should be the re-establishment of the entire intestinal function. Although the intestinal indigestion is probably the result of the weak nerve centres rather than the cause of such weakness, the two often act in such a vicious circle that our attention should be directed to the increased nourishing of our patient through the bettering of intestinal absorption. The matter of antotoxæmia and absorption of toxines in the intestinal tract in neurasthenia is still so problematical as a causative factor, and the treatment based on the supposition of such infection,—the use of cholagogues, intestinal antiseptics, etc., has proved so ineffective that we will pass over this part of our subject and consider what can be done to better facilitate intestinal digestion. The chief symptoms of many neurasthenics are attributable to intestinal indigestion; they are sufferers from what they call "nervous dyspepsia." The tongue is coated, they have various feelings of distress, distention, or abdominal pain, often coming on some hours after eating. They are usually constipated, sometimes with an alternating diarrhœa; they have very poor appetites, and have gradually left off articles of food which they thought disagreed, until their diet has become much restricted, and what they do eat is but imperfectly digested, a considerable proportion of the nutriment passing away in the feces. Consequently there has been a steady loss of weight and a noticeable softening and a growing flabbiness of their muscular tissue. Such patients should be put to bed under the care of a trained nurse of sufficient strength of character and force of will to get the patient completely under her subjection, so that the dietary measures will be strictly carried out.

If there is any evidence of colitis or an obstinate constipation it is my custom to have daily colon flushings of normal salt solution, given with the "high" tube and in quantities according to the sensations of the patient, usually from one to four quarts, at about 100° F. In the beginning the diet should be chiefly nitrogenous, meats, fish, eggs, milk; the nourishment coming at intervals of about three hours during the day, but only three regular meals; at the extra times egg nogs, raw eggs, or hot milk.

The patient will usually rebel at the very start; she will say that she cannot possibly take so much food, that she will suffer from indigestion intensely. If you have the right nurse and can acquire the proper mental influence over your patient you will soon convince her

to the contrary. As the digestive functions are really weakened to a considerable extent a temporary aid to digestion is often of benefit, and I have employed Taka-Diastase for this purpose with very satisfactory results. Taka-Diastase was suggested to me by Dr. N. Emmons Paine in consultation over an aggravated case of neurasthenia with marked mucous colitis. This digestant was then not generally known, but it proved so serviceable in this case that I was led to experiment with it in many others, and at last came to look upon it as almost indispensable. I have found that when using Taka-Diastase food could be taken in greater abundance, farinaceous foods could be added to the diet almost with impunity; that the patients complained less and less of their dyspeptic symptoms and that assimilation was undoubtedly increased. Not only this, but often after using the Diastase for a month or two with a liberal diet, the patient's general condition became so much improved that she was able to carry on digestion unaided when the Taka-Diastase was stopped. I adopted the use of this substance when our former digestive ferments were passing into disfavor, and was, to say the least, sceptical of the new one; but I soon became convinced of its real value, especially in these neurasthenic cases. Taka-Diastase not only was of decided aid in amylaceous digestion, but was also of assistance in the digestion of proteids. Besides its immediate chemical action in helping digestion, it seemed either to stimulate more or less permanently the intestinal tract to more vigorous action, or it had allowed of such improved nutrition that the normal functions of digestion became established. Whichever was the case, it was possible to soon discontinue the Taka-Diastase and the patient continued to digest her food with but little if any discomfort.

To recapitulate, I have found the following of most service in re-establishing digestion in neurasthenics: — rest, special feeding, colon flushings, and Taka-Diastase; but to these I would also add two others which the scope of this paper will not permit my discussing,— abdominal massage and the properly indicated Homeopathic remedy. Of the latter I must say this much, that more success has followed when the remedy has been selected according to the general nervous symptoms of the patient, than when its selection was based chiefly on the digestive abnormalities.

A FURTHER REPORT ON THE BENEFICIAL EFFECT OF GALVANISM IN SPINAL SCLEROSIS.

FRANK C. RICHARDSON, M. D.

In 1895 I reported to the National Society of Electro-Therapeutists, a series of cases of Tabes in which galvanism applied to the spine had proven of undoubted benefit in relieving the subjective symptoms of that disease. These cases had been carefully observed and were, to my mind at least, conclusive evidence that although galvanism might have no power to regenerate sclerosed tissue, its effect in relieving the subjective phenomena of tabes was well marked and unmistakable.

Since that report I have been able to confirm the statements then made by other cases of like nature and have convinced myself of its extended sphere of usefulness by observation of a number of cases presenting symptoms due to irritation of parts of the cord other than the posterior columns.

Without transcribing at this time the details of these cases from the record books, where they may be seen by those interested, I wish to say that in no less than seven cases observed in dispensary and private practice, the symptoms arising in the course of undoubted lateral sclerosis have been greatly mitigated by spinal galvanization. Not only has pain and other subjective symptoms been relieved, but there has been decided improvement in gait, tremor, etc., as well as modification of the ankle clonus and exaggerated reflexes.

So pronounced and constant has been this effect, even in cases under the most unfavorable conditions, that at the Dispensary clinic we confidently promise to at least help these patients.

All of the cases have been so well defined as to preclude the possibility of mistaken diagnosis, and that the ameliorations were due to electricity and not spontaneous has been demonstrated in many ways to our perfect satisfaction.

Much thought has been given to the satisfactory explanation of these good results, because we are unable to demonstrate that the current actually reaches the spinal ganglia, and other deep centres which are peculiarly insulated by reason of their boney enclosure.

While the recent and apparently tenable theory of the frequent peripheral origin of sclerosis may in a measure account for the sometimes remarkable effect of electricity, it does not seem to apply to every case. For example, to my mind only the direct action of the current upon the diseased tissue can explain why a man who for months has been unable to walk unsupported by attendants, should, after a few applications of spinal galvanization, walk into the clinic with the sole aid of a cane.

While I do not believe that any known therapeutic method is capable of regenerating spinal cord tissue which has once been destroyed and so do not claim galvanism to be curative of sclerosis, there are two points to be considered in discussing this subject. On the one side, as is generally conceded, in all these cases the primary irritation and damage is always more extensive than the permanent destruction; in other words there may be a degree of inflammation of surrounding tissue insufficient to cause destruction, yet sufficient to impair function. It is this tissue, as I believe, that is favorably influenced by the catalytic action of the galvanic current which, I have every reason to think, does reach the spinal ganglia, possibly by way of the spinal blood-vessels which are excellent conductors.

From a perusal of their writing on the subject, I am led to believe that the unsuccessful use of electricity in spinal sclerosis, reported by various authors, has been largely due to defective methods and perhaps I will be pardoned if before closing I mention briefly the method of application which has served me so well in these cases.

While it is doubtful if in these applications designed to influence deep centres, we get any polar action, strictly speaking, I have ordinarily made the cathode the indifferent pole over cervical spine, placing the anode over the lumbar enlargement. With the electrodes thus placed, a current of from 15 to 25 ma. is passed for three minutes; the current is then turned off and the anode moved upward about its length and the same current used for the same length of time. This process is repeated until every part of the spine has been covered, care being taken that the location of the indifferent electrode be sufficiently changed during the treatment to avoid too great surface irritation. In order to avoid pain and irritation of the skin, the electrodes must be large, measuring at least three by five inches. The skin should, of course, be thoroughly moist. All sudden variations in the strength of the current, especially interruptions and reversals are to be avoided. The current should be gradually increased from a feeble one until the required strength is reached.

To avoid all possibility of misunderstanding allow me in closing to state that I have never seen a case of sclerosis cured by electricity; I have observed the action of this agent in a sufficient number of cases, however, to feel satisfied that in galvanism we have an agent often capable of not only mitigating the symptoms of spinal scleroses, but not infrequently of modifying or even arresting the progress of these diseases.

DISCUSSION.

Dr. F. L. Emerson said he did not think this treatment was any longer an experiment, judging by the results seen in the clinics averaging ten to fifteen patients twice a week. In private practice you did not see so many of these cases. They are not cured, although some of the patients stopped coming at a time when they were very

much better. One case was a herdic driver, and he had seen him on his carriage since then, he having been previously in the Massachusetts General Hospital without benefit. Only one case not permanently benefited, although he was helped in the beginning. Walked at first with a cane, but later without it. Another came with crutches, who was able later to go about with a cane. The treatment undoubtedly benefited these cases.

Dr. Sara Johnson said she could corroborate what had been said. She had seen these cases frequently for the last year, and had seen some of them four years ago when an interne in the hospital, and they certainly showed improvement.

Dr. Colby knew that many of these cases were relieved by electrical treatment, and he was beginning to arrive at the conclusion that cases of tabes, if taken early are not so wholly incurable. Of one thing he was certain, that he had either seen two cases of tabes cured, or he had been mistaken in his diagnosis. If the latter was true then there were no rules by which you could be infallibly guided. He believed that in many cases of tabes the trouble in the beginning was not in the spinal neura, not central, but peripheral, it was not in the spinal ganglia, but in the peripheral nerves. Now this might not sound as if it meant anything to speak of, but it did mean that there are greater possibilities of relieving the disease if taken in season, than if we looked upon it as of spinal degeneration from the outset. He had arrived at the conclusion that spinal degeneration was secondary and not primary. Whether the spinal cord could be reached by the galvanic or any other form of electricity could only be determined from clinical evidence, but that kind of evidence we had always had to depend upon to a very great extent in our profession, and he was becoming convinced that it did reach the deep-seated structures. He would say in this connection that when this matter was first presented he had read a paper referring to a new electrode which he expected to work wonders. He could only say that it had not been off his shelf for some time, as he could not get patients to stand it. Static electricity is the most superficial of the whole series, it has small quantity and high intensity, and flows to the surface of everything it can, and yet with the induced current he could produce most deep-seated muscular contractions, and with the direct current he was satisfied that he had seen results in clearing up atheromatous neuritis within a month, and with no other treatment. If static electricity could reach the intimate coats of the arteries, he thought the galvanic current could be assumed to penetrate the cord, remedially at least.

PROCEEDINGS

OF THE

FIFTY-EIGHTH SEMI-ANNUAL MEETING.

OCTOBER 12, 1898.

The fifty-eighth semi-annual meeting of the Society was held at Steinert Hall, Boston, Wednesday, Oct. 12, 1898.

The meeting was called to order by the President, H. C. Clapp, M. D., at 10.30 A. M.

After the reading and approval of the records of the preceding meeting, Dr W. H. Weeks, President of the Vermont Homeopathic Medical Society, and delegate therefrom, was introduced by the President, and the good wishes of our sister society were extended to us.

Dr. J. Kent Sanders, of Cleveland, Ohio, was also introduced by the President, and in a few brief words expressed his pleasure at meeting with us.

At 1 o'clock the Society adjourned for lunch, after which the annual oration was delivered by Dr. George E. May.

After re-assembling at Steinert Hall, extensive amendments and changes of the By-Laws were proposed by Dr. F. P. Batchelder, and referred to the following committee: Drs. E P. Colby, J. P. Sutherland, J. L. Coffin, O. B. Sanders, C. L. Nichols.

Dr. J. W. Clapp moved an amendment abolishing the office of librarian.

Dr. David Foss moved that the dues be reduced from $5 to $3.

These amendments were also referred to the above-named committee.

ORATION.

SOME INFLUENCES TENDING TO MODIFY THE PRACTICE OF MEDICINE TO-DAY.

BY GEORGE E. MAY, M. D.

Not long ago, during a conversation with a homeopathic practitioner who has enjoyed a long and successful career, I was impressed with his statement that he practiced medicine in all essentials exactly the same as when he began forty years ago. Accepting, as he did, the law of similars as universal, nothing else was left beyond the perfection and elaboration of its teachings.

I think it altogether probable that others could be found, possibly within this Society, who would promptly echo the sentiment. And yet among the rank and file of us, who at least by fellowship and association, if not by practice strictly followed, are ranked as homeopathic physicians, there are many to whom each decade, if not each year, has brought something in change of methods. Such faith as that exhibited by the forty-years' practitioner just quoted is, I confess, "devoutly to be wished." It is a method that will stand the test of time, for which we all are searching; but how many of us can feel sufficiently satisfied with any method — even that based on the law of similars — to hold fast thereto, closing eyes and ears to all else which proffers itself? Are we not compelled to recognize certain factors and influences at work, and give to them some of our attention?

The orator who stood in this place two or three years ago discoursed most interestingly upon "Medical Fads," and warned us against the creation of any new ones or the adoption of any already made. Most certainly should we not run after every *ignis fatuus* that appears, and we should be even more careful lest we make of our own law of cure a fad.

I believe I appreciate the great honor you do me by inviting this occupation of your time and attention. What one of you could not have done it better? I make no apology, but simply suggest the anecdote of the amateur musician away out West, who, when officiating at a dance, always posted a large notice, "Don't shoot the fiddler; he's doing the best he can."

I thought I should find it easier to write my paper and then assign a name, but it is so rambling it is no easy matter to mention a proper title. I have simply tried to suggest *some influences tending to modify the practice of medicine to-day.*

I believe that notwithstanding the ceaseless train of patent and proprietary medicines, the great and only specifics, launched forth upon a gullible public by the vender, whose name is legion, through the modern art of advertisement in the daily and weekly secular and religious press, by means of flaming signs on rocks and trees, which mar the landscape far and near; notwithstanding the alluring pellet of the homeopathist and the imitative tablet of contemporary practitioners; notwithstanding the wonderful developments along the lines of analytic and synthetic chemistry, which have furnished such a mystifying hoard of therapeutic possibilities and, I may say, impossibilities, yet there never was a time when, in the profession at large and among the intelligent laity, so prominent place has been given to the *vis medicatrix naturæ*.

We are more and more critical in our analysis of every cure, and instead of accepting without argument each recovery on a *post hoc propter hoc* basis, we are asking ourselves, and are more ready to be asked, the question, how many of the acute diseases we are called to treat would after all get well just as quickly and safely without a drop of medicine, either crude or potentized?

In typhoid, in pneumonia, in erysipelas, in the exanthemata, how many of us feel positive that, after adopting all that hygiene can afford, by the giving this drug or that, in this dilution or that, we can add "one jot or one tittle" to the bettering his chances for recovery? I say, how many are positive, — and again, how many of the positive ones can bring forward evidence based on statistical records which will strengthen the faith of the skeptical?

We see patients getting well under the heroic treatment of some practitioners, others getting well under a more moderate regime such as probably finds acceptance by a majority of the membership of this Society, others who are recovering under the administration of medicine of such infinitesimal dose as to place it beyond the limit of scientific demonstration. Christian Scientists, faith curists, and those throughout heathendom who by incantations and spells pretend to cast out the evil spirit of disease, all claim their triumphs. But

> "Of all the ills that suffering man endures,
> The largest fraction liberal Nature cures.
> Of those remaining, 'tis the smallest part
> Yields to the efforts of judicious art.
> But simple kindness, kneeling at the bed,
> To shift the pillow for the sick man's head,
> Give the fresh draught to cool the lips that burn,
> Fan the hot brow, the weary frame to turn,
> Kindness untutored by our grave M. D's.,
> But Nature's graduate, when she schools to please,
> Wins back more sufferers with her voice and smile,
> Than all the trumpery in the druggist's pile."

I do not know of a more potent influence upon medicine to-day than the modern hospital, and the broader the foundation lines upon which the institution rests, the greater its power for good. Let physicians and surgeons of different beliefs meet in the ward and at the bedside. Let each see the work of the other and follow the results No surer way exists, or ever will, for breaking down barriers of bigotry and instruments of intolerance throughout the profession. I count my hospital experience as among the most valuable of any I have enjoyed, and not the least prized is an acquaintance and an association with men who are not members of this Society.

How the modern hospital is adapting itself to the needs of the day and generation! Its quiet, cheery, private rooms invite those who are able to have the best to leave the cares of home, the well-meant but often misplaced efforts of anxious friends, for the practical and scientific equipment of the hospital; and the laboring man who is overtaken by calamity may reap the benefit of all that medical and surgical skill can bring.

It is not too much to predict that another decade will see all contagious disease, except in the most rural communities, treated in hospitals; nearly all of surgery will be done there, besides much more in the way of general medical affairs.

Great evils, it is true, exist in the present hospital system. I need hardly to refer to them, because they are receiving a due share of attention at present. It is a matter of surprise and regret that in some of our large hospitals the attending physician is compelled by the rules to give his service without remuneration to persons even of acknowledged wealth who hire rooms, — the services of physician being held as included in the rate for attendance. Reforms are being undertaken in this direction, and justice demands a careful revision of hospital and dispensary rules bearing on the matter.

"Medical charity in hospitals and dispensaries should be freely extended to those who require it; denied to those who do not, and from ignorance or parsimony demand it. The community suffers if provision is insufficient or proper access is difficult. The community also suffers if no questions are asked, the independence and self-respect of the laity being undermined and the medical profession failing to receive returns which justly belong to it. Alike as citizens and professional men, we should carefully scrutinize the claims of every new charitable medical institution, and refuse our aid and countenance unless satisfied that it is likely to meet a real need in the community."

The hospital's influence is shown in another way, namely in the furnishing of statistics. The records of a thousand cases are of how much more educational value than those of any individual, no matter how much his experience. It is just such statistical information which broadens the view. It is leaving behind the days in which

medical men were accustomed to make great claims as to their powers, arrogantly pretending to control processes of nature which in reality we are unable to influence in any degree.

It is a matter for congratulation that our own Massachusetts Homeopathic Hospital has revised its methods of record, and statistics of much more value should be forthcoming.

Observe the influence of the modern insane hospital on the care of this class of patients, having brought about one of the most marvelous changes in all the history of medicine.

Another great product of the hospital and an element of vast import in medical practice to-day is the trained nurse. How much more effective all our suggestions when we are sure of their being carried out by skilled hands! How much more clearly can we interpret symptoms when recorded by the trained observer! Our profession can never be the same since the advent of Florence Nightingale and her followers.

Do athletics influence medical practice? Most certainly. The interesting invalid of a few years ago is becoming no longer interesting, but golf, cycling, camping, yachting and the college games constantly beckon our youth toward a healthful and invigorating life, in which pills and powders have no part, and no tonic save that of Nature's own *elixir vitæ* need ever be consumed.

How different the patient of to-day as to general information and intelligence from him of years ago. Education is doing so much to acquaint the public with methods of right living. Why, the average college graduate to-day knows as much physiology, nearly as much anatomy, infinitely more chemistry and sanitary science than did the medical graduate of a few decades ago. Any newspaper reader is capable nowadays of diagnosing appendicitis and often suggests treatment of some sort long before the doctor does.

The tendency to specialism has also a modifying influence on medical practice. The field of medical science is so rapidly broadening that no one now can do justice to all branches. To the specialist we now look where our fathers would have worked the case out alone, and possibly the patient would have succumbed for want of more precise knowledge. I sometimes wonder if the general practitioner will not yet become a mere detective, discovering here and there a a patient to turn over for treatment to his more fortunate brother, the specialist.

Greater skill in diagnostic methods, through a knowledge of bacteriology, pathology and the general etiology of disease has rendered our groping less constant and our treatment more direct.

Look for a moment at preventive medicine and behold what is being attempted. See architecture, both public and domicilliary, straining every point toward perfection in hygiene—through selection

of site, drainage, plumbing, ventilation, to say nothing of plans for comfort and pleasure.

What pains are being taken in the line of food to ward off pestilence and to provide the most nutritive and digestible substances. With the inspection of all meats, milk and many other of the staple articles it seems well nigh impossible that much of disease should originate in our diet. Behold the elaborate and practical system of quarantine, of school inspection, of street cleaning. How careful we are of our water supply.

How prevalent the annual vacation is coming to be, and how short the laboring day as compared with that of even twenty years ago. What is the effect? Is life more intense thereby and the candle more likely burned at both ends, and so after all the physician's labor increased?

Statistics show nervous disease to be on an alarming increase. Why? What effect has the screaming steam whistle, the banging gong and the ceaseless roar of the electric car, the unnecessary ear-splitting sounds of Fourth of July, the discords of German bands and other street venders? How far is the school system, with its tangled course, exacting discipline and inquisitorial examinations, responsible for shattered nerves and unhappy disposition? Are we not whipping up our nervous system in order to keep pace with rapid transit, with the flashing of intelligence over the wires and around the globe?

If such changes and many more have taken place in the physician's field of labor, how much also have the physician's opportunities for study changed? See the medical journals which bring their weekly or monthly store so freely to his desk. How has the graded course of study, the increased length of the college course and the broadening of its curriculum affected his professional equipment?

How many physicians now cross the ocean in pursuit of knowledge? How much nearer, by means of rapid transit facilities, have the great centres of learning been brought to the country practitioner?

While the physician's field in most directions has been broadened, in perhaps others it has been narrowed, as, for example, the gradual encroachment of surgery, as it has come to the relief of so many pelvic, abdominal, pleuritic and even cranial and spinal diseases.

Yet, is not much more referred to the doctor than formerly? Is he not more frequently and generally called in to the sore throat, to the colics, the colds, the corns, to the pimples, the piles, the pinworms?

I have no direct means of knowing, but I am of the impression that his advice is sought oftener than ever before. Let us hope that what he has to offer is also more valuable than ever before. None of our patients being present, perhaps I may safely ask if there were no minds to be relieved, no fears to be quelled, no hopes to be lifted, how many of us would stay in the profession?

And yet, have we really learned it all? Is there nothing new worthy of consideration, nothing worth striving for?

We used to prove drugs. I do not hear among ourselves of many new provings now. Physicians other than homeopathists are proving them. One of our members showed us how to critically analyze old provings so as to make them more valuable. How many are doing it? We learned of Hahnemann. Have we not also learned of Jenner, of Lister, of Pasteur?

How many of us can observe the statistics of diphtheria under anti-toxin treatment as compared with other methods and not wonder if after all something has not been learned in that direction. I believe that along the lines of serum therapy barely suggested by anti-toxin, by the tuberculin test, by the Widal reaction for typhoid, by vaccination, there is a great future for medicine—why not as great as the impetus given to surgery by the adoption of antisepsis and asepsis?

Let us not be found so much engrossed with what we have accomplished in the past—tho' brilliant be our record—that we fail to grasp the fruits of what scientific investigation is doing for medicine in general.

Does any strictly homeopathic method of treatment in typhoid fever give the promise which is given through the statistics of hydrotherapy as represented by the Brand or some modification of this method.

In the gastro-intestinal disorders of summer, are none of us in sympathy with those who find virtue in mild antiseptic measures, directed toward the modification of putrefactive changes in the alimentary canal. Who can deny the influence on medical practice of the opthalmoscope, the process of intubation, intravenous transfusion in shock and hemorrhage, or the marvellous possibilities of the Roentgen Ray?

In the light of such signs of progress, when men are turning from the narrow to the broad in nearly every department of life, when science is opening her halls and laboratories to every one who is of an investigating mind, when the trust of yesterday is the uncertainty of to-day and the experiment of to-day is the established fact of to-morrow, shall not liberality be our watchword? Shall it not be a motto, if not *the* motto of every true physician and emblazoned on the escutcheon of every medical society?

REPORT OF COMMITTEE ON DERMATOLOGY, SYPHILOLOGY AND GENITO-URINARY DISEASES.

WINFIELD SMITH, M. D., *Chairman.*

I. Dermatitis Herpetiformis. John L. Coffin, M. D.
II. The Initial Lesion of Syphilis, and its Treatment. A. H. Powers, M. D. Discussion opened by J. L. Coffin, M. D.
III. The Effects of Syphilis on the Nervous System. Edward P. Colby, M. D. Discussion opened by Frank C. Richardson, M. D.

DERMATITIS HERPETIFORMIS.

BY JOHN L. COFFIN, M. D.

Previous to the year 1884 the student in dermatology was not a little perplexed by the study of a class of diseases presenting erythematobullous lesions, and which were described under various titles. It remained for Dr. Louis A. Duhring in that year to recognize a more or less constant relation between the cutaneous lesions of these variously described diseases, and he presented to the profession a brochure under the title of "Dermatitis Herpetiformis," in which he included the various conditions mentioned above and maintained that all these conditions were but different manifestations of one disease. His contention at that time has since been accepted by almost the entire profession, and to-day dermatitis herpetiformis seems to be an established fact.

The disease is thus defined in Dr. Duhring's own words: —

"Dermatitis herpetiformis is an inflammatory, superficially seated, multiform, herpetiform eruption, characterized mainly by erythematous, vesicular, pustular, and bullous lesions, occurring usually in varied combinations, accompanied by burning and itching, pursuing usually a chronic course, with a tendency to relapse and to recur." *

Symptoms. These may in their onset be sudden or extend over from a week to ten days. When severe more or less prodomata are experienced, such as chilliness, malaise, constipation, fever and great itchiness of the skin without lesion. Following this the eruption appears, consisting of erythematous patches, groups of vesicles, papulo-vesicles, papules, pustules, or blebs, or a combination of any or all of these lesions on various parts of the body, occurring in groups. Although multiformity is the rule in the lesions of this disease, it is by no means constant. Not infrequently the lesions are

* Cutaneous Medicine, Part II, page 440.

all erythematous or all vesicular or pustular ; neither does the predominance of one type during any attack guarantee similar lesions in the next or any succeeding seizure. Different attacks may present types similar in character or so unlike in appearance as to make it appear like a distinct and entirely different disease. According, however, to the predominance of the character of the lesion in any given case, we recognize for convenience of description five varieties, namely : the erythematous, vesicular, bullous, pustular, and multiform or mixed.

The erythematous variety presents itself for the most part in reddened patches, like some of the forms of the exudative erythema. Urticarial elements are not uncommonly associated with this form and patches either discrete or confluent resembling erythema multiforme. The color may be any of the various shades of red common in cutaneous affections, tinged with yellow or brown and vanishing with various degrees of pigmentation.

The vesicular variety is the most frequent, the eruption occurring in small, pinhead to pea-sized vesicles, occurring in groups, generally without areola. The shape of the vesicles is often irregular, and when close together tend to coalesce, forming small blebs, irregular, sometimes stellate in shape. The vesicle wall is quite firm, and on being broken by scratching does not excoriate, but tends to refill. Itching in this form is most persistent and intractable, often occurring with intolerable energy before the appearance of the lesion and persisting with almost unabated fury throughout. The itching is often entirely out of proportion to the amount of cutaneous damage present. The bullous form presents typical bullæ, tense or flaccid, irregular in shape, with or without areolæ, and the groups are often surrounded by small pustules or vesicles.

In the pustular variety the lesions are for the most part pustules from the start ; they are from pinhead to large pea size, grouped, and not infrequently have a few vesicles in proximity to each group. The smallest pustules are flat, not much above the surrounding level ; the larger are raised, conical, or accuminate or puckered. According to Duhring, this variety is more apt to repeat itself in subsequent attacks than any other variety.

The papular variety is the rarest, as it constantly tends to merge into the papulo-vesicular. It does, however, sometimes occur over limited areas and presents the mildest form of the complaint.

The multiform or mixed variety is polymorphous in all respects, the various forms above described being generally mixed upon the surface of the body, showing erythematous patches covered with vesicles, papules, and blebs of varying sizes, shapes, and colors. Grouping of lesions is still prominent, the itching severe, and most cases at some time during their course present this type. Lesions have been observed in the buccal, laryngeal, and tracheal mucous membrane,* and

* Stelwagon's cases, Jour. Cutan. and Genito-Urinary, February, 1890.

in one fatal case supposed to have existed within the intestinal canal.* The course of the disease is essentially chronic, occurring in relapses, with from a few weeks' to a few months' interval and covering a period of several years. The etiology is obscure. While it sometimes occurs in people of apparent good health, there seems to be a consensus of opinion among those having had the largest experience in this complaint that mental shock, such as anger or fright and nervous debility due to anxiety and worry, are the most common causes. Duhring, Elliot, Crocker, Vidal, Brocq, and the author † have cited cases in which this cause was present.‡ James McF. Winfield ‖ and Sherwell § report four cases in which glucosuria following mental shock existed, and J. A. Fordyce ¶ a case complicated with albumen and casts in the urine.

That this disease is for the most part either a nervous reflex or a tropho-neurosis seems to be fairly well established. It may occur at any age, but is most common between the ages of thirty and sixty.

The pathology has been exhaustively studied by several authors, prominent among whom are Leredde and Perrin. According to them the diseased process consists in a very acute inflammation of the papillary layer of the corium, with œdema and the pouring out into the tissues of a vast number of polynuclear leucocytes and eosiniphile cells. Their researches have been confirmed by Davier ** and by Dr. Fordyce.††

This abundance of eosiniphile cells in the exudation has been thought by some to be somewhat pathognomonic of this disease, but as it also occurs in urticaria, pellagra, and pemphigus, it cannot be so considered. According to Neusser, it is an evidence of a phycosis and of marked vasomotor disturbance.

The diagnoses from cases of eczema, erythema, multiforme urticaria, and pemphigus are frequently made with difficulty, and is only possible by the contemplation, not of any single attack, but of the disease as a whole as it occurs in its various relapses and recurrences. The special diagnostic points are itchiness, very severe, especially before the appearance of any lesions, the grouping of lesions, which constitutes its herpetiform feature, its tendency to relapse, its chronicity, and its capriciousness.

The treatment of all cases reported has been far from satisfactory. Nothing so far seems to be able to prevent recurrences, which sometimes extend over a period of years with varying intervals. During

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* Lancet, July 11, 1896.

† *New England Medical Gazette*, December, 1895.

‡ Cutaneous Medicine, Part II, p. 444.

‖ Jour. Cutan. and Genito-Urinary, November, 1893.

§ Jour. Cutan. and Genito-Urinary, April, 1888.

¶ Jour. Cutan. and Genito-Urinary, November, 1897.

** Annals de Derm. et Syph., t. VII, pp. 842-849.

†† Jour. Cutan. and Genito-Urinary, November, 1897.

an attack arsenic has accomplished the most in affording relief and shortening the duration of the attack. On account of its probable neurotic origin it would seem that the arsenite of strychnia would offer even better results. As regards the local treatment, literature on the subject teems with a multitude of remedies, which is in itself a sufficient guarantee that but little success has attended their application. During the acute stage soothing lotions and dusting powders seem to have afforded the greatest relief, while later, Duhring claims the best results from vigorous inunctions with sulphur ointment.

THE INITIAL LESION OF SYPHILIS AND ITS TREATMENT.

BY A. H. POWERS, M.D., BOSTON, MASS.

There is hardly a more important disease than syphilis. The years which are liable to pass ere a radical cure is established, and the insidious attacks on any or all the tissues of the body, make it a topic of prime importance; and though little if anything new can be said, yet the discussion of some features of the initial lesion may prove of profit.

When the syphilitic virus comes in contact with the absorbents of the body of a person who is not immune, that person is infected with syphilis, and the manifestation at the point where the virus enters the body is called the initial lesion.

This initial lesion is present as soon as there is a break in the skin or mucous membrane, and the syphilitic virus comes in contact with the lesion and infects it; but there elapses a varying time before it is distinguishable as a chancre, and in some cases it is said to never become noticeable. The length of time from infection to the presence of a recognizable lesion varies, as you have so many times heard, from three to eighty or ninety days. This is the period of primary incubation. The much more common period of this primary incubation is from ten to thirty days, and yet we must remember that at times cases are seen at either extreme of the limit, and thus it is that we may need to be guarded in our diagnosis. After the infection has occurred then gradually appears a round cell infiltration about the vesicle, and this infiltration extends involving all the structures till there comes to be the indurated lesion which has so often been called the hard chancre. This infiltration may depend on the location of the lesion and the mechanical irritation to which the lesion is subjected. This induration is probably never absent, but it may be so slight that it is not recognizable to the touch. Often, however, there is such induration that the mass seems like a bit of wood or cartilage in the skin or mucous membrane.

There is besides this induration an excoriation or ulceration of the tissue at the point of infection, and this may extend to an area of

considerable size and lead to marked scarring and possibly some deformity which is permanent.

As a rule, however, the initial lesion leaves slight or no lesion relics behind when it heals, and the old suggestion to look for relics of the initial lesion on the genitals in case of suspected syphilis is valuable only when a positive, distinctive scar is found, and is not exclusive when absent.

There is a form of initial lesion which has slight induration and yet there is often marked loss of tissue, and there is, at times, considerable swelling and local œdema. I refer to the so-called mixed infection. When the same point is infected with syphilis and pus germs there often appears a lesion which has many of the characteristics of the "soft" chancre, and there is often considerable discharge and quite likely multiple lesions appear. The acute inflammation from the pus germs overshadow the effects of the syphilitic virus, and these cases when seen and treated are often considered simple sores till the later symptoms make the diagnosis clear.

There may be relapses of this ulcer occurring when nearly healed, and this may be repeated one or more times, thus constituting the relapsing chancre. It has been assumed that the soft chancre or chancroid is caused by the ordinary pus germs, but candor compels the admission that this is a question on which there is much difference of opinion.

The simplest form of lesion is that of the papula, which may be small, dry, flat, large, or moist. This simple lesion may be and often is unnoticed by patient, and may even fail to attract the attention of the attending physician.

Already I have intimated that an initial lesion may occur on any part of the body, and conservative estimates place seventy-seven per cent on the extra-genital parts of the body. This leads one to think that syphilis may frequently be acquired innocently, and we cannot assume that all genital lesions are *prima facie* evidence of debased morals. The truth is that from five to ten per cent of cases of syphilis are innocently acquired. The topic of the distribution on the body of the initial lesion is too great to speak exhaustively upon in a paper like this, and in passing, attention is called to the frequency with which it is found about the mouth, and here the angles and the tonsils are seemingly favorite locations. The initial lesion is more rarely seen in women than in men because it is within the vulva and causes no pain, and a slight discharge is not thought to be of much importance. There is one location, namely, on the breast of women, where I think it will be seen less frequently than in the past, since there are few wet nurses employed at present, and hence the danger of infection from syphilitics' children is lessened.

Coincident with the growth of the initial lesion there appears another condition, a part of the same disease, to which attention

must be called. This is the involvement of the neighboring lymphatic glands. Here we find not a single enlarged gland, as often occurs in gonorrhœa, but a chain or group of them; and these are usually small, hard, and freely movable under the finger, and not the boggy mass which may be found in glands infected from suppurating lesions. Abscess is quite rare in the glands infiltrated from the initial lesion, and I believe when an abscess does occur it is usually if not always in those cases of mixed infection, and the abscess is caused by the pus germs rather than by the syphilis. This involvement of the lymphatics is a most constant symptom and a great aid in diagnosis.

The initial lesion may be mistaken for an epithelioma or a simple chancre. Epithelioma does not usually occur before forty years of age and the lymphatics are involved very late. The duration of the lesion is also a point in differentiation. In simple chancre the induration is wanting and the glandular infiltration is of one, two, or three large soft glands liable to open from the retained pus. Secondary or tertiary syphilitic lesions may simulate the initial lesion, but the induration is not usually so distinct and the lesions, are not often solitary and there may be no glandular enlargement.

A history of other lesions or the presence of lesions or lesion relics will help to exclude the initial lesion. With herpes progenitalis there is no induration, no grandular involvement, and there are multiple lesions often occurring in successive crops.

The treatment of the initial lesion is a much-mooted point. There is an almost unanimous testimony that mercury administered internally causes the induration to pass away and hastens the healing of the lesion. That this is desirable is doubted by so able a syphilographer as Dr. R. W. Taylor, and he cites a number of equally noted men as favoring his idea. He would use all the time from the discovery of the initial lesion to the eruption of the secondary lesions in building up the general health of the patient, preparing his stomach for the ordeal which it must undergo, and making his teeth healthy and the gums firm. Those of us who believe in the more minute dose are not as liable to encounter gastric rebellion and spongy gums later in the case. For my part, I think that merc. biniodide or the bichloride can be used with benefit, and on these two forms of mercury I place most of my dependence. Locally the lesion should be kept aseptic if possible, and the first decimal trituration of calomel serves as one of the best dressings. Wash the lesion clean with a sterile normal salt solution, dry it carefully, and apply a liberal dusting of the trituration and cover with a bit of absorbent cotton. In some cases aristol has served me well. Once in a while a sluggish ulcer may be hastened in its healing by touching it with acid nitrate of mercury. With these simple means the initial lesion may be well cared for and the patient prepared for further lesions when they occur.

THE RELATION OF SYPHILIS TO NERVOUS DISEASES

BY EDWARD P. COLBY, M. D.

The more one studies either syphilology or nervous diseases, the more strongly does the impression become fixed that the infection exerts a marked influence upon the nervous system. It is second only to its effect upon the skin, and it is but natural that these results should be numerically related, both tissues being developed from the same embryonic layer, and such kinship is not without its physical relation. In the meantime, we must bear in mind that it makes no trifling difference whether we pursue the study from the point of view of syphilitic nervous diseases or from that of nervous diseases in syphilitic subjects, and there exists no small amount of confusion among authors upon this very interesting division. We all recognize the existence of such a condition as "nervous syphilis," with definite and unmistakable specific lesions, occurring at no very distant times from other syphilitic manifestations, that is, within a very few months or years. On the other hand, there are several degenerative nervous diseases in which a very large percentage of cases present a previous history of specific infection. If these diseases occurred only in patients with such history, there would be some ground upon which to class them as syphilitic; but unfortunately for such theory these same affections occur in a very respectable percentage of patients who present no such history, and where, in fact, there is every reason to exclude the probability of infection. To establish a diagnosis of syphilis, patients should present some marked symptoms by which the nature can be differentiated, something by which we can identify a specific from a non-specific case. In these late manifestations such stigmata do not exist, and we can only argue from the history of the case.

One patient who has many years before had a primary specific lesion, finally develops, for instance, ataxic paraplegia. Another person who has no suspicion of such affection is attacked by the same disease, and between the two there is nothing but the verbal history to show the slightest difference. In reality there may be a greater parallelism than in two syphilitic subjects. In several of the degenerative nervous disorders it is claimed,—and probably truthfully,—that there is a percentage all the way from 50 to 80 of specific antecedents. To be conclusive, there should be no break save that of incorrect or doubtful history; in other words, there should be 100 per cent.

The argument that if the whole family record could be known we should find inherited syphilis, is not tenable in this country to any

great extent, and it is remarkably singular that a robust child should grow up to robust manhood tainted with such dyscrasia and not show one specific indication until the third or fourth decade of life. Some other characteristic symptom should crop out previous to the appearance of the nervous affection. It is a significant fact that most of our statistics upon this subject are from countries with large standing armies, composed mostly of single men, and constantly exposed to decidedly immoral influences, and syphilis is so common a holding that it would be difficult to select any chronic disease for study which would not furnish a large percentage of syphilis in its personal history. Another method of estimate has been suggested but never adopted. Not how many ataxics or paretics had had specific disease, but how large a proportion of syphilitics have these disorders. Such a census would make a very interesting study, and possibly it might be profitable.

True syphilis of the nervous system is not so very frequently encountered, and when it does occur it is a comparatively early feature. Most of the cases develop within two years of the last somatic lesion, and a large proportion within the first year. Its most common forms are meningitis, the characteristic disease of the cerebral and spinal arteries, and gumma. Of the vascular nervous supply the cerebral is most frequently attacked, and gummatous growths seem to prefer this area to all other central tissue. The symptoms are by no means uniform, but depend upon the locality involved; thus we get local paralysis, which may be multiple. If there be local palsies multiple in number, and not in correlated areas, occurring in a syphilitic subject, we may confidently expect that the lesion causing such palsies is specific in its nature.

Buzzard, who is a careful student with abundant opportunities for observation, calls attention to one feature which he seems to consider characteristic; it is the profound somnolence. But care should be exercised not to confound this with the somnolent form of hysteria, a rare condition occurring in markedly hysterical subjects, who are free from syphilitic taint. If there is gumma in the brain it is quite likely to cause optic neuritis. The endarteritis of syphilis cannot easily be differentiated from that of other causes, except that it occurs in younger subjects, and is, like the other specific lesions, amenable to the administration of iodide of potash or mercury, and often a case which does not yield to the potash will improve under the administration of mercurius.

Paretic dementia is without doubt an occasional occurrence, but lately attention has been directed by an author to two assumed facts: that syphilitic paresis occurs within two to five years after the initial lesion, while true paresis does not often occur before ten or more years. Also that in true paresis the psychic symptoms predominate over the somatic, while in cerebral syphilis the somatic symptoms pre-

cede and dominate the psychic failure. Attention has been called to the use of iodide of potash and mercury not alone for their curative power, but also as diagnostic agents.

Now it is a generally accepted opinion among neurologists that in post-syphilitic degenerative diseases these drugs do but little if any good. In true specific disease there is a cachexia for which the drugs have a selective affinity, while in the non-specific class the primary disease has acted as do many other factors, to disturb the equilibrium and render the patient subject to morbid action. There is nothing here upon which the drugs can act selectively.

Again, the true syphilitical lesion is to a certain extent exudative, while in the other and late malady the lesion is strictly degenerative. Many syphilologists and pathologists claim to have demonstrated that in true specific lesions of the nervous system there is an infiltration of small, round celled characters similar to that which is found in gumma; this even in endarteritis and specific meningitis. No such infiltration has been found in the late lesions like paresis and cord disease. The theory prevails to a great extent to-day that the original germ leaves a toxine which predisposes to degenerative action. This may be true, but it is singular that it should not in some way manifest its morbific influence until so many years have elapsed. The latency would be truly remarkable. Fournier has termed this condition parasyphilitic.

Syphilitic meningitis cannot be readily differentiated from chronic meningitis of other origin. It is more likely to be more locally defined, and in a large number of cases it is only an extension of an underlying gumma. When it occurs over an extended area it is less likely than the non-specific variety to cause optic neuritis. Non-specific meningitis running a more or less chronic course and not the result of trauma or alcoholism is not common. Septic meningitis is almost invariably acute. In estimating the time following syphilis to establish the value of the terms, early and late, it must be borne in mind that we cannot always count from the initial lesion. A series of secondary lesions has a tendency to extend the time, and would make a late lesion — in point of time — early in reference to the specific history. Syphilographers tell us that such instances are not rare.

Authority is about equally divided on the question of whether thorough treatment in the early days of the disease has any effect in averting post-syphilitic degenerative disease, and both sides present a large array of illustrative cases. There now presents itself to us a momentous question: Can medication in accordance with our accepted method be of any benefit? While there is a very general opinion that the syphilitic virus is an entity which demands appreciable dosage and for a long time, yet there is a great probability that the post-syphilitic condition is one in which minute doses of remedies appropriate to the total symptoms may be of great benefit. This is on the same princi-

ple that we would use properly chosen remedies for their constitutional effect after an injury or any non-specific disease. As previously noted, syphilis is one of the disturbing causes, and being of considerable duration it most profoundly weakens the resisting power of the whole economy against morbid tendencies. We must constantly bear in mind that pathological processes are only physiological workings "gone wrong," and the causes which can initiate this error are innumerable.

There is good reason to believe that we are no more helpless in facing this enemy than many others which we are constantly combating. But there is a period beyond which our efforts will be futile. If we wait until nervous lesions of a degenerative nature are well established we have lost much valuable time, and it is doubtful if the lost ground can be regained. These diseases, being degenerative, are consequently progressive, and the primary lesions carry with them other secondary results. Central nervous tissue has but little recuperative function, and at best we can only hope to arrest, but not to repair. The disorder is to a greater extent in conducting tracts than in ganglionic tissue, which does not add hopefulness to the case. I do therefore most firmly believe that a course of carefully conducted constitutional treatment should follow the specific medication, as preventing non-specific, but consequent, disease. Occasionally, but not often, we read of one of these late cases being relieved by specific treatment. There is no rule by which the post-infectious state can be treated save the important one to study carefully the symptoms.

Another question is of importance to us: Does the continued heroic treatment to which the early disease is subjected have any influence upon the development of late disease? We all know that continued administration of mercurial compounds to the non-syphilitic affects the constitutional habit most profoundly, and that many of the symptoms thus produced are almost identical with those caused by the specific infection, and unless we can argue that the virus uses up the mercury, so to speak, the whole economy must be saturated by it and its effects. Nor is there any method of deciding without doubt whether a large portion of late lesions may not bear disagreeable relationship to the primary treatment. The very uncertainty as to the ultimate value of early and thorough treatment would be an argument in favor of the unreliability of such treatment. And yet how few of us would have the courage or temerity to withhold the use of such measures as are known to cause the disappearance of a majority of true secondary lesions? The extended use of mercury since the true nature of the disease was first recorded gives us but a small number of cases from which we can study the results of pure and unmodified disease.

We are actually placed "between the devil and the deep sea," and must make our selection as to which horn of the dilemma shall impale

us. In one instance we must risk our good reputation and fly in the face of recognized authority ; in the other we must bear the imputation of having added an unnecessary danger to the life and happiness of our patient. One thing is certain, we cannot carry our patient through the secondary stage of the disease in a way which will save us from criticism with simply imponderable agents. The secondary stage left to itself is not entirely free from danger.

DISCUSSION.

In regard to Dr. Coffin's paper, Dr. Powers feels that many cases of dermatitis herpetiformis escape recognition. Thinks that palliative treatment is the only one which has been satisfactory.

In the case of the initial syphilitic lesion Dr. Coffin believes in the nomenclature of recent writers calling the chancre initial lesion, and chancroid chancre.

Pus sore generally occurs within a few days of exposure, true lesion later. In certain cases initial lesion is a very innocent looking affair, but should be regarded suspiciously. Spoke of glandular enlargement of lingual and submaxillary as unmistakable evidence of late lesion, especially if a mucus patch accompanies it, which does not yield to treatment, with less pain than would be expected. Such a throat must be regarded suspiciously.

Believes in early medication, because infection of system certainly takes place at time of initial lesion. Small doses of merc. taken at start and followed persistently certainly aids. Locally does not believe in cauterization, but in perfect cleanliness. Washes, peroxide solution, and dusting, calomel and boracic acid.

Dr. Krauss feels the fact should be emphasized that syphilis may occur without demonstrable initial lesion. Point of infection does not necessarily develop into typical lesion. The character of the lesion varies greatly and is difficult to make out, and he does not believe that a diagnosis should be made without positive evidence. Regards syphilitic bubo as the only characteristic symptom, consisting of small cell infiltration into substance of gland. This is the most important sign, and is evidence beyond contradiction.

REPORT OF THE COMMITTEE ON SURGERY

WILLIAM F. WESSELHOEFT, M. D., *Chairman.*

I. Goitre. Horace Packard, M. D. Discussion opened by Alonzo Boothby, M. D., and John P. Sutherland, M. D.

II. Adult Club Foot. Geo. H. Earl, M. D. Discussion opened by J. W. Hayward, M. D., and A. H. Powers, M. D.

III. Intestinal Fistulæ. William F. Wesselhoeft, M. D. Discussion opened by J. B. Bell, M. D., and J. E. Briggs, M. D.

GOITRE. — A GENERAL CONSIDERATION OF THE DISEASE WITH REPORT OF CASES AND CONCLUSIONS.

BY HORACE PACKARD, M. D.

The importance which any disease assumes is in direct proportion to its local or general prevalence.

I cannot recall that the subject of goitre has ever been brought before this society. The reason undoubtedly is because in this country it is a relatively rare disease, and even when it does occur, seldom reaches a magnitude, or produces symptoms which seriously menace the patient.

In my whole experience of eighteen years I have met perhaps, all told, large and small, fifteen cases of goitre. The most of these have drifted under my observation through the recommendation of other physicians with surgical treatment in view. It is probable that the average of physicians in general practice, see in the course of a lifetime in this country a much smaller number than this. It is my hope that in the discussion which will follow this paper, the experiences of my colleagues will be forthcoming.

A goitre is an enlargement of the thyroid gland, resulting either from an increase in the follicular, the fibrous, or the vascular structures which enter into its composition.

An exaggeration of the follicular elements results in a cystic goitre in which there may be one or more cysts, filled with a fluid of varying consistency. The diagnosis of this form of goitre is usually easy, especially after the tumor has reached an appreciable size. If there

be doubt the aspirator needle will settle the question. It is ordinarily symmetrical.

An increase in the fibrous tissue gives us fibroid goitre. In this the enlargement is of great density, hard and unyielding; and usually asymmetrical.

The vascular form of goitre is of exceptional interest because it introduces us to the consideration of exophtholmic goitre, known otherwise as Graves' disease and Basdow's disease. This form is as interesting as it is obscure. Interesting because of the tumultuous action of the heart, protrusion of the eyeballs, and occurrence in women only. Obscure, because we know nothing of its cause, the relation of its manifestations, and little of its cure.

This disease may make its appearance at any time from early infancy to adult age. The enlargement may be confined to one lobe only, or may involve both symmetrically. The progress of the disease is usually benign in character; simply an augmentation of the existing structures. Occasionally it is the seat of malignant disease; carcinoma or sarcoma.

With the benign variety there sometimes occurs, where great enlargement exists, such interference with the function of the gland that widespread systemic disturbance follows. These are seen in the countries where the disease is endemic, as Styria, Tyrol, and Switzerland.

Practically all the knowledge we possess of the function of the thyroid gland is inferential and has come about through the strange sequelæ following its transformation. The terms myxœdema, cachexia-strumipriva, acromegally, and cretinism, have been applied to these conditions, and a person so affected is termed a cretin.

Where goitre is endemic, and the children begin life with this disease, the victims are short in stature, deficient in intellect, devoid of reproductive power, and frequently deaf and dumb.

Cretinism sometimes occurs without thyroid enlargement, is most often seen in the offspring of parents in whom the disease is well established, but may occur sporadically without any such antecedents.

According to all information which I am able to secure upon the subject, cretinism and myxœdema are rarely seen in this country. Evidently the deterioration of function is rarely sufficient to profoundly effect the whole organism. The only case I have ever met occurred in a woman who had never known any enlargement of the thyroid gland, and whose parents were exceptionally strong.

Most extensive research has been made to determine the cause of goitre and its sequelæ. Obviously the localities where this disease is endemic afford the best opportunities for such investigation. The hospitals in all the large cities adjacent to Styria, Tyrol, and Switzerland have hundreds of cases annually.

All the natural surroundings of communities have been subject to

the keenest scrutiny. The air, the water, the soil, and all the habits of life, have been persistently examined. It has been claimed, and with no little justification, that the lime and magnesia found in the natural water supply of these regions may have much to do with it.

Probably no one has made a more exhaustive study of the disease in this relation than Dr. Kocher, of Berne, Switzerland. According to his investigations in the regions where goitre is most prevalent the soil and water are rich in organic material; and it was further noted that families which were entirely free from goitre possessed a water supply of exceptional purity from some adjacent spring. The drift of his conclusions are that organic material in drinking water, possibly in the form of micro-organisms, may be the real cause.

All these theories, however, are open to question, the cause is as yet unknown.

REPORT OF CASES.

Case 1. Very early in my professional career, the first year I think, a woman of about 35 years consulted me regarding a bunch on the neck. It was a case I was particularly desirous of curing, hence I made a very careful study, and to still further fortify myself sought the counsel of a physician many years my senior. The tumor occupied approximately the middle line of the neck just below the thyroid cartilage, and was without question a goitre. The general health otherwise was very excellent; there were, and had been, no cardiac or ophthalmic symptoms. It had reached a size easily noticeable in a few weeks, and was the source of much anxiety to the patient on account of the disfigurement. It was evidently a goitre of follicular or fibrous origin, possibly a combination of both. As the result of consultation Arsenicum was the remedy decided upon. No immediate effects followed its administration, and the patient in her anxiety for results sought the counsel of another physician. I learned a few weeks afterwards that the tumor had perceptibly diminished, and later entirely disappeared. I was informed that the remedy administered was Iodide of Potash in large and increasing doses even to complete saturation of the system evinced by marked cutaneous irritation.

Case 2. Mrs. C., a woman of 50 years, made her appearance in the Massachusetts Homeopathic Hospital in one of the very earliest terms of my service, bearing upon the anterior aspect of her neck a fairly symmetrical tumor, soft but not fluctuating. As I view this case at this remote date, I believe it was an exorthalmic goitre, although the accompanying symptoms were not sufficiently manifest to suggest it to me then. She was placed under treatment consisting of parenchymatous injections of ten drops iodide three times weekly. This was continued with no appreciable results for three weeks. An operation was then undertaken having in view the removal of the tumor. On cutting through the overlying skin and connective tissue, and exposure

of the goitre, multitudinous dilated veins were found crossing and ramifying the tumor in every direction. Every cut that was made was followed by a gush of blood difficult to control. Efforts to find a limiting capsule, which should present sufficient cleavage to permit of enucleation, failed. Deeming that the best interests and the prolongation of the life of the patient would be conserved by stopping at this point, all bleeding vessels were secured and the wound closed. The case soon after disappeared from my view, and I am in ignorance of the subsequent progress.

Case 3. Dr. L., a physician from Hot Springs, Col., consulted me for a large left-sided goitre. It had gradually of late increased in size, and was on my examination about nine inches in circumference the smallest way. All method of medicinal and local treatment, including electricity, had been tried. Operation was performed, and a solid, well-circumscribed tumor, involving the left lobe of the thyroid only, removed. It was singularly free from adhesions, the capsule was distinctly marked, and its cleavage was excellent. The wound healed without incident, and recovery was complete.

Case 4. Mrs. B., of Denver, Col., consulted me through the recommendation of the preceding case, for a tumor of the neck. On examination I found a very prominent fluctuating tumor occupying very nearly the median line of the neck, at the side of the thyroid body. As an aid I used the aspirating needle, which withdrew a limpid, straw-colored fluid. On incision the cyst wall was found exceedingly thin and friable. With care, however, a prolonged dissection with sharp-pointed, curved scissors, the whole cyst wall was enucleated. It was an exceedingly slow and painstaking operation on account of many and dense adhesions. The remainder of the gland seemed in a healthy condition, and remained undisturbed. The patient made an uncomplicated recovery, and has had no further trouble.

Case 5. Miss L., a teacher, of robust constitution, had, at the close of a year of hard work in school, coupled with heavy and wearing responsibilities in her home, a symmetrical enlargement of both lobes of the thyroid. The enlargement was well defined, resistant on palpation, and cardiac and opthalmic symptoms were absent. She was placed upon the following treatment: 90 grains of iodide of potash and 20 drops of tincture of iodine were dissolved in 5 ounces of distilled water. A teaspoonful of this was added to a pint of water, and this amount was taken daily with the meals. The increase in the goitre ceased, it gradually reduced in size, and at my last interview, now three or four years ago, the enlargement had entirely disappeared.

Case 6. Miss C., of Fall River, Mass., was referred to me by Dr. D. A. Babcock. She presented an unilateral enlargement of the thyroid involving the right side. It was a solid tumor, evidently of the fibroid variety. It had caused her no inconvenience other than

the embarrassment incident to the disfigurement. It was removed without incident, and convalescence was satisfactory.

Case 7. Mr. Y., of Dedham, Mass., was referred to my hospital service in 1897 by Dr. F. L. Babcock. He was in excellent health other than a cervical enlargement which had gradually made its appearance in the preceding few months. This was a hard fibroid enlargement of the left thyroid lobe. It was successfully removed without incident.

Case 8. Miss W., a young woman of 25, was the protege of one of the benefactors of the Hospital, and came into my term of service in 1895. She had the largest double goitre of any case which has come under my personal observation. The right lobe was enlarged to such proportions that it nearly filled the space between the inferior maxillary and the clavicle. The left lobe was but moderately enlarged, the trachea and the esophagus were markedly displaced to the left of the median line. The jugular and carotid, of the right side especially, were also subject to great displacement and depression. It was a case in which the tumor was well outlined, was dense and resistant, and afforded the most favorable outlook for successful operation. She was a devout Christian, and tried to view the matter in a conscientious light. She finally decided that it was the will of God that she should have the goitre, and consequently she would not try to escape the punishment He had inflicted upon her. I have no knowledge of the subsequent history of the case.

Case 9. Miss R., of Portland, Me., appealed to me through the recommendation of a mutual acquaintance for a cystic goitre. This was very similar to case No. 4, except that the cyst extended very deeply into the tissues of the neck, a portion of it being adherent to the thyroid cartilage. It was, as in case No. 4, dissected away with great difficulty, and the rest of the gland allowed to remain. Most excellent convalescence followed.

Case 10. Miss B., a graduate nurse of the Massachusetts Homeopathic Hospital, presented a typical case of exopthalmic goitre. The action of the heart was tumultuous, the carotids pulsated wildly, the eyes protruded, and both lobes of the thyroid were enlarged, symmetrical and compressible. Belladona 3 x was administered, and after the lapse of a few weeks improvement, and finally full recovery followed.

Case 11. This deserves a report by itself, and really has no place in this paper; for there was never any appreciable enlargement of the thyroid, hence was never goitre. It was, however, the only case of myxœdema which I have ever seen. I have hoped that the case would be reported ere this by the family physician, but since it has not, I may be pardoned for placing it upon record here.

In 1895 I was summoned by Dr. W. O. Faxon, of Stoughton, in consultation over a case of suspicious abdominal enlargement. An

examination under ether failed to disclose any growth in the abdomen or pelvis. The patient had a chalky complexion, large, pendulous bags under the eyes, a large, pendulous abdomen, and dullness of intellect which had gradually crept over her in the past several years. After careful study of the patient, and consultation with Dr. Faxon, we decided that we had a case of myxœdema. To summarize, I will only add, leaving the details for Dr. Faxon's personal report, that the patient was placed upon a treatment consisting of tablets made from desiccated sheep's thyroid, with the result that in the course of a few months she was practically cured. The interesting part of this story is that the patient was my relative, whom I had known since my early boyhood, and prior to my medical studies I had noticed the beginning flabbiness of the tissues of her face, and had known of the mysterious illness which was creeping over her. She had sought counsel, both local and urban, without avail, and had finally given herself up to the slow progress of the disease, believing that there was nothing in the science of medicine available for her relief. In these intervening years, and in her enforced invalidism, I had rarely seen her, and knew little or nothing of her progress; but the disease had gradually crept on until it presented the unmistakable picture outlined above.

TECHNIQUE OF OPERATION FOR GOITRE.

The line of incision for the enucleation of goitre is preferably along the inner border of the sterno-mastoid muscle; on one side only, if unilateral; on both, if a symmetrical goitre.

The close proximity of important structures, notably the carotids and jugulars; the sympathetic, the pneumogastric, the phrenic and the recurrent laryngeal nerves; the trachea, the larynx, and the esophagus; necessitate the greatest circumspection in dissection.

The vascular supply is always augmented. Hemorrhage is one of the greatest obstacles encountered; the only safe course to pursue is the immediate ligation of every vessel the moment it is cut; the exposure in the early part of the dissection of the capsule of the tumor, and never departing from its surface throughout the whole operation. Any wandering off into the maze of adjacent tissues is likely to result disastrously, either in the wounding of some important vessel or injury of the laryngeal nerve. I would say that I have never had difficulty in this respect in any of the operations which I have performed. These important structures have never been obtrusive. My object has been to avoid them by keeping close to the surface of the tumor in my dissection.

Since the advent of antiseptic surgery the mortality after goitre operation is practically nil.

The ligating of bleeding vessels forms no inconsiderable part of the surgical technique. It is a common thing to adjust from sixty to

ninety ligatures. The arterial blood supply comes largely from the superior and inferior thyroid arteries. These are greatly augmented in size in large goitres, but it is usually possible to expose them and ligate before cutting. Any interference with the recurrent laryngeal nerve which is in close proximity to the posterior surface of the thyroid, results fatally through paralysis of the muscles of the larynx and suffocation.

THE SEQUELÆ OF GOITRE OPERATIONS.

A danger, the possibility of which always obtrudes itself upon one's mind, is the occurrence of myxœdema following thyroid extirpation. All the knowledge we possess regarding this comes to us from the surgeons of the hospitals in or near the provinces where goitre is endemic. If the more recent reports be authentic, the danger from this source has been overestimated.

It appears that in the experience of some surgeons who have massed large numbers of cases, a case of myxœdema has never been seen. Kocher, Billrotch and Maas have reported myxœdema as altogether absent or exceedingly exceptional.

It is argued then that some portion of the gland must have been left, and still performs its physical function, but this is hardly tenable, for in the majority of cases every appreciable portion of the gland tissue has been removed. The fact remains that the relation of the thyroid gland in the economy of the body, or as a factor in myxœdema, is still exceedingly obscure.

In cases where myxœdema has occurred following thyroid extirpation, attempts have been made to cure through engrafting a portion of the thyroid gland of the sheep. This has fallen into disuse, and in its place the feeding to the patient of the desiccated thyroid or the administration of thyroid extract is adopted. This method of treatment has repeatedly shown its efficacy, and is, I think, now a well established therapeutic measure.

CONCLUSIONS.

1st. Goitre, on account of its infrequency, is a comparatively unimportant disease in this country.

2d. This is sometimes curable, especially in its early stage, through the internal administration of iodine or iodide of potash.

3d. It is a disease amenable to cure through surgical operation, and under present methods of surgery the danger is practically nil.

4th. The danger of myxœdema following thyroid extirpation is very slight. When it does occur, the administration of the thyroid of the sheep affords a very reliable means of relief.

DISCUSSION.

In re the paper by Dr. W. F. Wesselhoeft, "Intestinal Fistulæ," Dr. Bell said that in suspected fistula, not showing any presence of fæces, the oxygen gas was a good test. This soon found any spot of leakage, and could be quickly tested by the application of a lighted match. He did not think the speaker included rectal fistulæ which sometimes follow vaginal operations. He remembered one troublesome case, but which finally did much better than expected. In those old cases of salpingitis the tissues are very apt to take on a hard, firm formation, so that removal of the diseased mass often leaves a very thin wall to the intestine, The rectal wall, instead of being of good, firm consistency, presents a membranous appearance not one-third of the ordinary thickness. In a case of this kind an opening was made into the rectum during an operation, which was, however, closed with a Lambert suture, but a small fistula into vagina followed. This closed after three to four weeks, but as a rule they are rather troublesome cases. He thought it was very desirable to collect all the testimony upon these cases that could be done, so that we might have reliable data in the matter.

Dr. D. W. Vander Burgh said he wished to supplement his report of intussusception presented at the last annual meeting. There has been no further sloughing off of the intestine. There was no tenderness about the abdomen, nor any evidence of a tumor. The patient was able to sit up for three to four hours daily, but during the intense hot weather of the past season she rapidly lost strength, and died during the middle of September.

Dr. W. J. Winn said he wished to refer to the case of appendicitis mentioned in the paper. Dr. Earl had been called to see the case before he had any knowledge of it. When seen by Dr. Earl there was a large swelling in the side, apparently close under the skin, for the examination was difficult on account of the excessive adipose development of the patient. On puncturing this tumor there was an immediate escape of fæces along with the rest of the contents. Later she was brought to the hospital, and on incising the abdomen the appendix was found sloughed off and lying free within the cavity of the tumor as described. Nature had walled off the end of the colon where the appendix had sloughed off, and the abscess cavity had burrowed out through the abdominal wall to the skin. The patient certainly had a very narrow escape, and the case shows the danger of delay in these cases. He desired to place himself on record as of the opinion that the time to operate in cases of appendicitis is as soon as you have made your diagnosis.

Dr. A. Boothby said there were two or three points referred to in the paper with which he did not agree. He did not think that fistulæ occurred as often as seemed to be intimated in the paper. He could only recall two, possibly three, such instances in his own practice, and had known of a very few in the experience of others. He certainly would not advise the vaginal operation on account of the possibility of this complication. He preferred the abdominal operation in every case, and thought there was a much greater danger of wounding the ureters than there was of wounding the bowel. The few cases of fistulæ seen by him closed without any serious trouble. As a matter of fact, these fistulæ often existed before the operation, discharging regularly and freely into the bowel. He would not advise operation through the vagina for pus tubes, for you usually have more than one pus cavity, and the single puncture does not remove the whole trouble. Even if there is only one cavity it takes a long time to cure the condition. That was the result of his observations, as he had had no personal experience.

Dr. Bell said he had seen very few fistulæ after the abdominal operation.

Dr. Wesselhoeft said that there was a misunderstanding about his reference to the frequency of these cases. He had only intended to refer to those cases which had been complicated with fistulæ; he did not know how frequently they did occur. He would like to ask Dr. Boothby if, in the so-called pelvic abscess, tubal abscess, he preferred to operate through the abdomen. Dr. Boothby replied that he did.

Dr. Horace Packard thought that in regard to the matter of pus tubes or pelvic abscess, the greater danger resulted through the abdominal operation. It had been his experience in the last few years, since operating in these cases *per vaginam*, that the patient made a better convalescence, and the general results were better. By removing tubes, ovaries and uterus, you make a complete and successful operation. After the tubes and ovaries have undergone the changes connected with pus formation, they are no longer serviceable, and by this operation you get a free drainage of the infected parts. There is not the danger of smearing the walls of the intestines and the edges of the wound with purulent infection as there is in laparotomy. It was a foregone conclusion that there must be great danger of infection under such circumstances. He thought that the views of his colleagues would agree with his, that the vaginal operation was the better one.

Dr. Boothby was certain that in doing a vaginal hystectomy you exposed a much larger surface to the passage, and infection, of pus

than by the abdominal route, and a surface, too, which was much more absorbent than the peritoneum. It was a fact that there was no trouble about obtaining sufficient and perfect drainage from above. Besides you did not leave a pus cavity, it was all dissected out.

Dr. A. Boothby, discussing the paper by Dr. Earl on "Adult Club-Feet," had not seen the patient since the operation, at which he was present, as remarked by Dr. Earl; and it seemed to be an extremely severe operation at the time, yet the results fully warranted the operation, as shown by the patient to-day. He could assure the members that the feet were just as bad as they looked to be, just as bad as represented by the casts. Anyone seeing them before the operation would have been very doubtful of any success or result, yet the case had gone on beyond any expectation, fully beyond anything promised. A point he would make was that when Dr. Earl started to operate, he did it. By that he meant that he did not get frightened, and only half did it. After the operation the feet could easily be brought into position and kept there without any straining upon the sutures of the wound, and this was an important part of the operation.

Concerning the paper by Dr. Packard on "Goitre," Dr. Boothby had very little to say in criticism. He might take exception to one remark, and that was that in the removal of the thyroid body there was very little risk to the patient. He presumed he meant in the matter of the removal only. The textbooks referred to it as a hyperplasia or hypertrophy of the thyroid body, but he was inclined to think that that was not altogether correct, but that the enlargement which took place only involved a part of the thyroid body, and that the removal as described was apparently simple, and without risk, because the entire thyroid was not removed. These conditions seem to be rather an encapsulated body within the thyroid, than in the thyroid itself. His own impression was that the thyroid body was not in a capsule, but rather extended to a certain degree into the surrounding tissues. He was led to believe, from recent observations by others, that the removal of the entire body was a serious matter. Conditions similar to tetany were set up, which later might lead to myxœdema. He did not think that anyone advocated the removal of the entire body, but only a portion, as one portion was generally more involved than another. As these swellings sometimes disappear without operation, the question of medical treatment is to be considered. Under medication they have also disappeared, but whether due to the treatment was, of course, a question. Iodides seemed to work in some cases, and again not in others.

Dr. J. P. Sutherland thought he had had more than the average number of these cases as they come to the general practitioner,

having treated some twelve to fifteen cases, two cases under observation at the present time. He was inclined to emphasize the idea that what we saw in this country of this class of cases was different from those of other countries. Again, the enlargement must be treated as a symptom, for no one would consider the enlarged lymphatic glands, in the strumous diathesis, for instance, to be the disease, but only a manifestation of something back of it. So he was inclined to think that these enlargements in and of the thyroid were manifestations of a deeper seated disorder, whether of the blood or not he could not say. He could recall one case, that of a young married woman, 27 years of age. He was called in to be present at an operation for lacerated cervix. While she was taking ether he noticed an enlargement over the trachea. It was not a large growth, but was distinct enough to determine that it was in the right lobe of the thyroid. After the operation she was never well, although the surgical wound had healed successfully. The pulse never came down from the high frequency it reached during the operation, but kept up without any regard to treatment. The enlarged thyroid and rapid, irregular pulse were later followed by some exophthalmos. A year and a half later she developed tuberculosis, and died from the latter cause.

Another patient, now about 45 years of age, came under treatment for metrorrhagia, which was treated in various ways. During an examination of the case he found a goitre on the right side. The patient had a peculiar leaden hue of the countenance, also a dark, bluish, purple color of the tongue. Has all the symptoms of neurasthenia, which are numerous enough, as we know. For several years has taken at intervals desiccated thyroids. While these did not increase the heart action, she has gradually lost flesh, and so the thyroids have been given in less quantities. She had recovered from the metrorrhagia, but tires easily. He had lately discovered the presence of a chronic nephritis, which may be a partial cause for the fatigue. The specific gravity is 1006 to 1008, with a few hyaline casts. The goitre is not so large, and her general health seems better.

A third case was that of a young lady, an art student, 20 years of age. She has a very pasty look, somewhat œdematous, with a rapid action of the heart, and easily fatigued. There is an enlargement of the thyroid, with a pulse rate of over 100, even after sitting still for some little time. It is more or less regular, but continues the above rate. She says that she had, seven years ago, an attack of typical chlorosis, but got over it. In 1892 had typhoid pneumonia, and this left her in the present condition of bloodlessness. He doubted this since seeing her brother recently, and who has a very similar appearance. She has a smooth swelling in the lower portion of the neck, which is noticeable by others. There is more or less a sensation of choking at times. The tumor, although apparently hard to the touch,

fluctuates in size. Lately she had complained of a feeling of pressure behind the eyes. A microscopic examination of the blood surprised him, for he found it practically normal; no evidence of chlorosis or anemia, while the blood discs were of good size, color and shape. Leucocytes were present in fair proportion. She had had belladonna and the thyroid extracts. During the summer she was at the seashore, and reports feeling better, with the pulse at 80 to 90, but still tires easily, and he doubted if she would be able to follow her studies throughout the winter. Had also given iodide of arsenic intercurrent with the belladonna. The tumor still fluctuated, but pressure behind the eyes was gone.

Desiccated thyroids did not appeal to him theoretically, although he used them, any more than the dry tissues of any other organ, although he could accept their use on the basis of a food element.

Dr. A. M. Cushing said that he never failed to relieve this condition with iodine given in the morning and spongia at night.

REPORT OF THE COMMITTEE ON MATERIA MEDICA.

FREDERICK A. DAVIS, M. D., *Chairman.*

I. Comparative Strength of Tinctures. J. Wilkinson Clapp, M. D. Discussion opened by Edward P. Colby, M. D.
II. Notes on Apomorphia. Mary S. Hornby, M. D. Discussion opened by Frank C. Richardson, M. D.
III. Lyssin. Chas. W. Morse, M. D. Discussion opened by Frederick Bosworth Percy, M. D.
IV. Massachusetts Air in Treatment of Tuberculosis. H. C. Clapp, M.D.

COMPARATIVE STRENGTH OF TINCTURES.

BY J. WILKINSON CLAPP, M. D.

The desirability of securing uniformity of methods in the preparation of homeopathic tinctures has long been recognized. As early as 1868 the American Institute of Homeopathy appointed a special committee, with Dr. Carroll Dunham as chairman, to prepare a Dispensatory which should embrace pharmacy. This committee was engaged in the preparation of such a work eight years, the death of Dr. Dunham preventing its completion. The results of the labors of this committee were not made available.

In 1886 and again in 1887 special committees were appointed by the Institute to consider the question of publishing a pharmacopœia. Both of them reported in favor of taking such action, and both advised that the British Homeopathic Pharmacopœia be made the basis. The reason for such recommendation was that the English tincture-making process secured uniformity of strength and gave a definite and well defined unit of strength as a starting point for attenuation. As a result of the reports and recommendations of these committees, the Institute in 1888 appointed a committee of twelve members, six of whom were pharmacists and six physicans, selected with special reference to their fitness for the work assigned them, they being recognized students of materia medica, chemistry and pharmacy. This committee was instructed to prepare a pharmacopœia and to take the British Homeopathic Pharmacopœia as a basis.

After nine years of labor, the work has been completed and has received the full endorsement of the Institute, the medical press, and such members of the profession as are qualified to judge of its merits. Of the twenty-four homeopathic pharmacists in the United States, ten have adopted it as their sole standard while others use it in connection

with other pharmacopœias. It is to be regretted that certain other pharmacists for trade reasons have assumed a hostile attitude toward the work and have sought by misrepresentation to prejudice the profession against it. While not a single scientific objection has been raised against any portion of the new pharmacopœia, much has been written to grossly misrepresent it, more especially as regards the strength of tinctures resulting from its use.

It is not my purpose here to reply to these false statements, but to call your attention to a few facts relative to the strength of tinctures made in accordance with (1) the rules of the Pharmacopeia of the American Institute, (2) Hahnemann's original directions, (3) the rules of other pharmacopœias at present in use; also to call your attention to the designation of drug strength as given by these different authorities.

The American Institute has adopted the English system for making tinctures as it secures uniformity in preparation as well as in strength. Under the so-called English system the dry crude drug is made the unit of strength; in other words, the starting point from which to estimate strength. From this it should not be inferred that all tinctures are made from dried plants, etc. On the contrary, the fresh green substances are used whenever possible, and the moisture contained therein is used and considered part of the menstruum. With very few exceptions, tinctures are made to represent one part by weight of the dry crude drug in ten parts by measure of the tincture, and as a result in many instances the tinctures actually contain all the soluble constituents of more than fifty per cent. of the fresh succulent plant. As, for example, Belladona, which contains 667 parts plant and 470 parts alcohol. It should be understood that a tincture is a simple solution of the soluble constituents of drugs and that its strength is limited to its point of saturation. It differs from a fluid extract in that the latter is made much stronger by concentration or super-saturation. Drugs vary much in degree of saturation, and it has been found that in the preparation of tinctures the proportion of 1 to 10 is the strongest it is expedient to use, as the majority of drugs cannot be exhausted with a much less quantity of menstruum, and many require even more than this amount. Jahr, who certainly will be recognized as one of the best of homeopathic authorities, considered 1 to 20 a better proportion, and so directed in his pharmacopœia. On page 30 "Jahr's Pharmacopœia and Posology" we find the following :

"As to the proportion in which alcohol ought to be added, many physicians have proposed to make it 1 to 10 instead of 1 to 20—that is to say to pour but 10 parts of alcohol on the pulverized substance—but independent of the certainty there is in the proportion of 1 to 20, the vehicle will necessarily take up all the medicinal virtues, and the tincture of many substances, as cinchona, opium, ratanhia, etc., seem to be in this proportion so fully saturated that it is very doubtful whether, in the proportion of 1 to 10, they would really acquire more energy."

Quin's Pharmacopœia, once a standard homeopathic authority, requires the same proportion, and the "Pharmacopée Homeopathique Française" of France, published the present year, adopts the proportion of 1 to 20.

The rules of the Pharmacopœia of the American Institute are such as to secure with but few exceptions tinctures representing one part crude drug to ten parts menstruum, and the strength is so indicated, ϕ–1-10. This makes the crude drug in each case the unit of strength. Such a system enables us to make our dilutions and our triturations correspond in strength. To illustrate: The 3x trituration of Nux vomica contains in each grain 1000 grains of the pulverized drug, and the 3x dilution represents in each minim 1-1000 grain of the crude drug.

Is it not easy to comprehend the great advantages gained by this method of designating the strength, since it gives us a unit always of the same value, thus securing uniformity and enabling us to know the exact drug strength of all attenuations? For example, the sign 2x will always indicate 1-100 grain crude drug, whether in solution, dilution or trituration.

Hahnemann directed that tinctures to be prepared from dried substances should be made in the proportion of one part drug to ten parts alcohol. It will be observed, therefore, that this class of Hahnemann's tinctures are the same in strength as those made by the rules of the Institute Pharmacopœia.

Hahnemann directed that tinctures from green, succulent plants containing large quantities of moisture should be prepared with equal parts of the juice and strong alcohol. Now, as most succulent plants contain upwards of 80 per cent. of moisture, it is clear that the amount of menstruum used, consisting of the alcohol and plant juice, will equal a larger proportion than 1 to 10. Further, in this class of tinctures he did not provide for macerating the plants, but only for using the expressed juice. As a result, this class of tinctures, representing about 1-12 of the entire list, are much stronger if made according to the rules of the Institute Pharmacopœia. The result of analysis may best indicate this. Tinctures of aconite and belladonna, made with equal parts alcohol and fresh plant by expression, and others by maceration, show the following results by analysis:

Aconite ϕ contains	By Expression.	By Maceration.
Dry residue	3.38%	4.84%
Alkaloids	.03944%	.07142%
Specific gravity	.9543	.9885
Belladonna ϕ contains		
Dry residue	2.32%	3.27%
Alkaloids	.04335%	.06703%
Specific gravity	.9513	.9729

This evidence should be conclusive and prove beyond contradiction the superior strength gained by the employment of the English method, as set forth in the Pharmacopœia of the American Institute of Homeopathy.

The larger class of Hahnemann's tinctures, from fresh green plants, roots, etc., he directed to be made in the proportion of one part drug to six parts alcohol. As but few medicinal plants contain less than 50 per cent. of moisture, it will be noted that this is in greater proportion even than one part crude drug to ten parts liquid. It would seem, therefore, that Hahnemann endeavored to arrange his classes of tinctures so as to secure a standard of strength somewhat near this proportion. It will also be manifest that the methods employed by Hahnemann and by the Pharmacopœia of the American Institute do not differ in any marked degree in the quantity of menstruum used. It can be justifiably claimed, however, that by improved methods the strength of our preparations has been increased, and that uniformity has been secured.

The rules of the British Homeopathic Pharmacopœia for the preparation of tinctures are essentially the same as those of the Pharmacopœia of the Institute; in fact, as previously stated, the Institute has adopted the English system.

Previous to the publication of the Pharmacopœia of the American Institute, Jahr & Gruner's Homeopathic Pharmacopœia was employed by a large number, if not by a majority, of homeopathic pharmacists in this country, and it is still recognized as authority by several of our pharmacists in good standing. The rules of this work subdivide tinctures into three classes:

1st. Those made from dried substances in the proportion of 1 to 10.

2d. Those made from fresh, succulent plants, using equal parts plant and alcohol, the tincture being prepared by the process of maceration.

3d. Those made from fresh plants containing less moisture; these in the proportion of one part plant to two parts alcohol.

It will be noted that tinctures prepared according to the first two classes will not vary essentially in strength from those made by the Institute Pharmacopœia.

Of the third class, where made from plants containing upwards of 70 per cent. of moisture the resulting tinctures will be of less strength; where below 70 per cent., apparently of greater strength; but this is entirely dependent upon the nature of the plant and the quantity of menstruum necessary to exhaust it. The difference in most cases is only apparent, not real.

Finally, we will consider the strength of tinctures made according to the rules of Schwabe's Polyglottica Homeopathica and the so-called American Homeopathic Pharmacopœia. These works are essentially the same, the latter, as far as rules of pharmacy are concerned, being a reprint of the former. They give rules for the preparation of tinctures under four distinct heads or classes, as follows:

1st. Those made from succulent plants by use of one part expressed juice with equal parts of alcohol. Estimate of drug strength, $\frac{1}{2}$.

2d. Also of succulent plants made with three parts plant to two parts alcohol. Estimate of drug strength, $\frac{1}{3}$. This class includes but a limited number of medicines.

The rules for these two classes are based upon Hahnemann's original directions, so that what has been stated previously in relation to resulting tinctures will apply to these also.

3d. Tinctures from fresh plants by use of one part plant to two parts alcohol. Estimate of drug strength, $\frac{1}{3}$.

4th. Tinctures from dried substances by the use of one part plant to five parts alcohol. Estimate of drug strength, $\frac{1}{10}$.

The claim is made that the rules for the preparation of tinctures given in these pharmacopœias are taken from Hahnemann's original directions. This is far from correct, as for the preparation of tinctures corresponding with the third class he directed the use of six parts of alcohol to one of plant, and for tinctures prepared from dried substances he made the proportion 1 to 10. It would seem that Hahnemann was better versed in the laws of pharmacy than some of his successors. He knew that in the preparation of tinctures, with few exceptions, drugs cannot be exhausted with any such small proportion of menstruum. If the compilers of these pharmacopœias had but followed Hahnemann, the literature of homeopathic pharmacy would have been at least less deserving of hostile criticism.

As to the designation of strength. The tinctures of the Pharmacopœia of the American Institute are, with but few exceptions, designated as ϕ 1-10 1x, the dry, crude drug being made the unit; in other words, the starting point from which to estimate strength. Classing them as 1x, first decimals, has led to misinterpretation and also to much in the way of misrepresentation. Still this is the only system indicating plainly the exact drug strength of our attenuations. The absurdity of the system of Schwabe and the American Homeopathic Pharmacopœia is shown by comparison.

A tincture containg equal parts juice and alcohol is designated as having a drug strength of $\frac{1}{2} = 50\%$, the water present being included as part of the drug strength. It would more correctly be designated at $1\text{-}20 = 5\%$. While a tincture made with one part dry, crude drug to five parts alcohol is classed as having a drug strength of but $1\text{-}10 = 10\%$. This, if fully exhausted by the menstruum, would possess a strength of $1\text{-}5 = 20\%$.

By this system a tincture possessing but half the strength of one made according to the Institute Pharmacopœia is designated as five times as strong.

The Committee on Pharmacopœia of the American Institute of Homeopathy has issued its work with the conviction that homeopathy has advanced to that stage which will warrant the application of scientific rules to its methods in pharmacy. Is not the homeopathic profession ready to approve this action and give it its support?

NOTES ON APOMORPHIA.

BY MARY S. HORNBY, M. D., DORCHESTER, MASS.

In the spring of 1893 my attention was first called to the use of apomorphia in hysteria, by a physician who stumbled upon its use, having given it to an hysterical patient to control vomiting, and thereby curing a severe form of hysteria. This is the only authority I have for the use of the drug in the following case:—

On May 4, 1894, I was called to see Miss S., age doubtful, probably from forty to forty-two, tall, slim, sallow complexion, dark hair and eyes, nervous temperament, constipated habit, inveterate coffee drinker, occupation that of a clerk. Family history showed tuberculosis on the maternal side, paternal side negative.

I was called to relieve the patient of an attack of hysteria, which expressed itself in that familiar form of uncontrolled laughter followed by weeping. I mixed twenty drops of nux mos. 3x in one third of a glass of water, ordered two teapoonsfuls every fifteen minutes until relieved, then once in two hours. In an hour's time she was out calling on some friends, where I had an opportunity to observe her through the remainder of the afternoon and evening. Though the outward expression of the hysteria was subdued, I saw that she was suffering from some intense nervous tension. I could not gain her confidence, except that she was worried about some home affairs, and had not been eating for several days, but drinking black coffee. I discontinued the nux mos. and gave several doses of nux vom. 2x. She retired late. It was about midnight when I heard a loud, sobbing sound coming from her room. I pushed open the door, and saw her half seated, half falling from a chair; her head thrown slightly back and to the side; eyelids partly closed, with the eyes rolled back; mouth partly open; the right hand grasping the neck of the nightdress, the left hanging listlessly at the side; respiration short and very shallow, with this peculiar sobbing sound that one sometimes hears in very severe attacks of asthma.

Later I noticed that the muscles of the chest were drawn in, as in extreme expiration, and remained in that spasmodic condition, relaxing only sufficiently to allow her to take a very short inspiration. The face was livid, the pulse full and slightly accelerated. I threw the window open near which she sat, bathed her hands and face with spirits of camphor, and held it to her nostrils. In a few moments she recovered, perfectly conscious, smiling and saying, "Thank you, I'm better now," and immediately relapsed into the same condition.

In a lucid moment I helped her to the side of the bed, where she sat

from twelve to three o'clock without falling, her body inclining to the right and swaying in that direction. In each attack her right hand grasped her throat, as though she were smothered; the left hung at the side. I gave a tablet of moschus 2 x every twenty minutes until two o'clock, with the result of seeing the faint grow more profound and last longer. I had asked for counsel and been refused on the plea of not wanting people to know. I felt positive that this was a phase of hysteria. I remembered the doctor's experience with apomorphia and determined to try it. I gave one twentieth of a grain tablet, by the mouth, once in twenty minutes, with a marked improvement in half an hour. A new symptom appeared, that of eructations of gas, so violent and prolonged as to cause exhaustion and severe pain in the left side. These attacks always terminated in this way. At half-past three the nerve wave had passed over, and though exhausted, the patient was bright and willing to talk about her condition. At four she fell asleep, sleeping soundly until seven, when she went to her work, looking and feeling as though nothing had happened. She had had an attack on the night previous to this, but had had no assistance. I advised a tablet of apomorphia night and morning, but was obliged to discontinue it after the first day, owing to the extreme diaphoresis it produced, and I was finally obliged to control it with jaborandi.

In 1895 and 1897 she had two attacks which were controlled within an hour with apomorphia, with the same diaphoretic result following. The patient has been thus afflicted since childhood, the attacks coming on about midnight and passing off between five and six in the morning. She knows when they are coming, and can hold them in abeyance for a time, but they finally overpower her. She has a step-sister and cousin similarly afflicted.

I will call your attention to two other uses of the drug that I have had an opportunity to verify. These are as an emetic, and its opposite, to prevent emesis.

The first was employed in the case of a child five years old, who had eaten the thorn apple, stramonium. One twentieth of a grain was given hypodermically, and emesis followed in ten minutes.

The second was also employed in the case of a child who was suffering from an attack of gastritis, when ipecac and nux vom. made no impression upon the nausea and vomiting. One twentieth of a grain of apomorphia on the tongue relieved the vomiting almost immediately, and nux and arsenicum completed the cure.

LYSSIN (HYDROPHOBIUM). SALIVA OF A MAD DOG. A NOSODE.

BY CHAS. W. MORSE, M. D.

The first saliva was obtained by Hering, August, 1833; proved by himself the same year, and by Schmid in 1835.

The disease of rabies was known to Aristotle 400 years before Christ. Rabies is an acute febrile disease; the temperature runs from 101° to 103°, but may be very much higher. The temperament is irritable, accompanied by spasms and convulsions. Warm blooded animals are subject to it, such as sheep, goats, horses, mules, badgers, apes, rabbits, rats, mice, chickens, pigeons. Apes, hens and sheep reduce the potency of the virus passed through them.

The smallest particle of virulent saliva or brain matter produces a fatal general disorder in which the infection is multiplied and pervades all the organs and liquids of the body.

Early spring, before the advent of hot days, shows a number of cases of rabies. A dog bite is not rabific unless bitten by a rabid dog, though the latter may be in violent passion. The teeth of a dog may be infected from eating carrion, and produce septicemia, but not rabies. Rabies, like most microbic diseases, is first confined to the region of the bite,—the tissues are alone infected. When fully developed, infection is a resident of the blood and all the vascular tissues. The surrounding lymphatic glands are enlarged, and painful sensation is felt along the nerves, extravasation of leucocyts into vessel sheaths and surrounding connective tissue. Drying of saliva or blood apart from heat or putrefaction does not destroy its virulence. Knives fouled in rabic animals have been used for successful innoculation months and years later. Mangers and feeding dishes charged with expectoration are dangerous. One man was infected by using his teeth to untie a rope which had been used to tie a mad dog. He died of hydrophobia. Fleas and lice which have lived on a rabid dog have communicated the disease to persons.

The active agent of hydrophobia is a micro-organism of the blood found constantly, which stains with methylene blue placed on potato at 25° to 27° C. It develops in the course of forty-eight hours in flattened, hemispherical cultivations of a color varying between whitish gray, yellow and citron. In test tube cultivations it behaves like the bacillus of Asiatic cholera; further research is needed to establish the connection between this micro-organism and hydrophobia (Yaksch).

PRODROMA.

The first few days consist of change of habit, emaciation about the eyes, mouth and nostrils, restless, frequently changing position, sullen and irritable. Some dogs are more confiding and fawning, and liable to infect by licking masters or others.

There may be dullness or apathy, later hyperæsthesia, starting at the slightest noise, sudden passion when he sees another dog or cat, jumping in the darkness, disposed to seek seclusion and wander about by himself, tearing things with his mouth and rubbing his chops with his paw; does not respect his master, swims a river, and has no fear of water; later twitching of muscles of face and general convulsions come on; power to raise the hind limbs gradually lost, first swaying unsteadily, then resting helplessly upon the ground, and occasionally raising himself by his fore limbs.

Cases are recorded where symptoms of hydrophobia have developed one to seven years after the bite, but these are not well authenticated. During the first few days of an attack of hydrophobia there may be some uncertainty as to the character of the disease. Stiffness of the neck may be mistaken for rheumatism, but is soon followed by trismus, which clearly points to tetanus. In trismus due to dental irritation, inflammation of the temopro-maxillary joint. In strychnine poison onset is sudden. In hydrophobia the first symptom is difficulty in swallowing.

Tetanus: clonic, rigid, persistent convulsions, involves muscles of deglutition; trismus affects respiration.

Hydrophobia: tonic and intermitting; lower jaw constantly in motion; affects muscles of mastication.

The sight of liquid causes a feeling of suffocation or convulsion, violent retching and vomiting. A remarkable and dangerous feature, like the dread of water, peculiar to man, is the spitting out of saliva on all sides, which can no longer be swallowed. For a time the mind is clear, paroxysms emerge into fits of mania, charging all those about him with having caused his suffering. When paroxysms cease reason resumes its throne.

A delay of several hours or days is no excuse for omitting to cauterize the wound. It has a good moral effect in preventing lyssophobia, and it is certain to destroy a part of the poison found in the wound.

PATHOGENESIS.

Mental symptoms. Thoughts of something terrible going to happen come into his mind against his will; feels impelled to do something reckless. His mental faculties are in a superior state of excitement, as shown by a clear perception and amazing acuteness of understanding and rapidity with which he answers questions.

The late Dr. Lewis Whiting, of Danvers, had a patient who possessed all the above symptoms. Her extreme age prevented her being sent to an asylum, and she was completely cured by lyssin, so there was no recurrence of the symptoms.

There is also an exhilaration as from joyful news, exalted state of the senses, taste, touch, smell, etc., and a fear of being alone. Is in mesmeric rapport with people, knows everyone, and answers questions, and knows what is going on in the next room. The patient may become furious, unmanageable; bites attendants. After attacks of fury evinces great regret at his behavior, making earnest apologies, warning those about him not to allow him to injure them. There may be chilliness, headache, weariness, depression, irritability, irascibility, ungovernable restlessness which compels motion. There is usually restlessness and anxiety about the præcordia, frequently changing position, sighing, incessantly driven hither and thither without any definite pain (Arg. nit.)

Lillium tig. has similar pains usually due to uterine or ovarian irritation, disposed to curse, strike, think of obscene things, associated with heart symptoms, such as palpitation, sensation as if a hand alternately grasped and relaxed the heart. The thought of liquids, drinking or swallowing, or the offer of anything to drink, sudden flashes of light, noisy movements, attempt to touch a patient, the glitter of a mirror or polished surface cause spasms of the throat, increasing jerking articulation and difficult swallowing, producing great distress and even convulsions of the throat. Range of ideas extremely limited, bringing forward the same idea in a short time in the same manner. The head feels particularly light, a vacillating or waving motion deep in the brain, surging towards the vertex, sensation of rush of blood to top of head (an aura). There are throbbing, pressing pains passing through forehead, occiput and to the nape of the neck. The eyes are red, cornea inflamed, a wild, distorted, staring, livid appearance, pupils dilated, eyes seem to project, vision impaired, with vanishing sight. The inflammation of the cornea may go on and pus collect under the closed lids. The ears are so sensitive that the sudden shutting of a door, ringing of a bell cause sudden starting; also running water or barking of a dog. Smell is particularly acute.

Face is red and drawn and distorted, slight twitching and quivering of the muscles, increasing until a most horrid assemblage of features is presented, involuntary grinding and gnashing of teeth, the expression of the face indicates anxiety and alarm, mental and physical misery. The skin may become pale, sallow or ænæmic, bloated all over, no pitting; chronic camp diarrhœa, jaws are sore and stiff, with pressure on top of the head, worse when there is pressure on the jaw; the mouth is dry, parched and sore, feels as if full of lumps, always a large amount of viscid saliva. It is said that the saliva is never found

on the outside of the lips. There is great difficulty in speaking a sentence, being begun only after several fruitless attempts. Usually the tongue is moist, though in later stages it is dark brown thick coating and dry. The lymphatic glands are enlarged and painful; sensation is felt along the nerves from neighboring lymphatics. There is frequent spitting and dribbling. With all this spitting there are no cases reported with much enlarged or sore salivary glands. This frequent spitting of tough saliva has led me to use lyssin in salivation of pregnancy. The throat is much inflamed, there is difficulty in swallowing, the frequent desire to swallow painful and ineffectual on account of the severe pains; fluids returned through the nose; warm drinks like milk and soup more easily taken than water. Attempts to swallow solid food result in attacks of suffocation, spasms of the respiratory muscles as well as those of the face, neck and rest of the body. Swallowing aggravates the heart symptoms. There may be partial paralysis of the epiglottis. There are stinging, burning, stitching pains common in the laryngeal and œsophogeal nerves, and may cause spasms of the œsophagus. The patient has a vicarious appetite, swallowing everything that comes in his way, as bits of wool, paper, wood, coal, pieces of leather. Food passes through undigested, followed by an uncontrollable thirst. The stomach is inflamed, though generally empty. There is a noise like the bubbling of water in the stomach. The mucous membrane of the stomach and intestines is much inflamed, injection of blood vessel and hemorrhagic infarct. There are colicy pains and cramps in the muscles of the abdomen, and a drawing downward of the abdomen and thighs. The lymphatic glands of the groins are enlarged. Dysenteric stools, with tenesmus during and after stools, worse from noise, running water, etc.

CHRONIC CAMP DIARRHŒA.

Passage of blood which is generally tarry, difficult mucous stools, with burning, prickling pains and protruding piles; urine scanty and muddy, greenish yellow; often in camp diarrhœa must pass urine, hears water running, with cramps of the bowels and extreme weakness after voiding urine. Priapisms, with frequent emissions during sleep, atrophy of testicles and in hydrocele. Prolapsus of the womb, consciousness of having a womb (helonis), copious catamenia, with offensive white leucorrhœa, sensitiveness of the vagina, frequent discharge of blood during menses through the rectum, showing pelvic engorgement. In puerperal convulsions patients have strange notions, desire for peculiar things, as coal, wood. There are cramps in the bowels, protracted salivation and diversion of blood to the vertex, sighing, with pains about the heart. Drinking water causes violent spasms of the muscles of the neck and throat, as if plunged in cold water. The pains about the heart are shooting, sticking, from loud

noises generally associated with a warm wave through throat and head (au aura). First the heart beats 80, full and hard, becoming more frequent, irregular and variable, worse after a paroxysm until it counts 120 to 180 and threadlike. All the time severe pain in the neck and centers of coördination, extreme hyperæsthæsia of the spine, the sterno clydo mastoid muscles stand out in bold relief, like thick cords. There is a look of mingled anxiety and terror on the countenance, a feeling of malaise and fatigue in the arms and legs, followed by convulsions and cramps, resembling chorea. Motions of any sort produce dizziness and shocks in the upper part of the brain and pains in the neck and spine. The patient has a strange, trembling feeling, as full of fear and forebodings, pains in old scars long since healed, sleeplessness, inclined to yawn, stiffness of the lower jaw, inclinations to gape and stretch, "tired all over," dreams, frightful, disconnected, dog fights, insane asylums; wakes up nervous as if something was going to happen, salivation and perspiration about the head, pains in the heart; pains worse in damp, warm weather, yet cold draughts of air produce spasms. Stinging, burning, tearing pains, with most exquisite sensitiveness of the whole body, especially the special senses, is characteristic, followed by numbness, convulsions and paralysis. Spleen is enlarged, with frequent stitching pains, "a die away" feeling about the heart, affects nervous tissue principally, blueness of veins, bones ache and joints crack, bluish discoloration of bitten place (Lach.), enlarged lymphatics. Slightest touch brings along convulsions (Strych.)

POST MORTEM CHANGES.

There are changes in the gray matter of the brain, spinal cord and bulb, and in connection with motor centers are characterized by accumulation of lymphoid cells in all the coats of the vessels and in the peri-vascular lymph spaces, along with granular and hyaline matter. The ventricles of the brain are full of dark serum, signs of inflammation in the larynx, bronchia and trachea, and emphysematous condition of the lungs.

It is reported that in an animal so peculiarly susceptible to rabies as the rabbit, they are able to secure immunity under most dangerous conditions (such as sub-dural infection), the vaccinations all being performed at one time, and treatment delayed even until symptoms are far advanced. The operators consider that the question of systematically vaccinating all dogs calls for serious consideration. Ghose reports a case cured by eleven sub-cutaneous injections of pilocarpin hydrochlorate, 1-5 grain each in the course of seven days. He excised the scar and left the wound open two weeks. This relieved the shooting pains felt in the scar.

Dr. Boujanus, of Moscow, relates the story of a very ferocious dog in his yard, often noticed tearing serpents (viper) to pieces. The

head and neck of the dog were often stung by these serpents and very much swollen. The same dog was bitten by a mad dog (and another dog bitten by this animal grew rabid). The former dog was severely injured and shut up to be shot. At first alarming symptoms appeared, soon subsided, and he remained in perfect health.

A reporter found a woman who had been stung by a serpent and bitten by a mad dog, remained in good health.

Painting the throat with a 5% solution of cocaine relieves the spasm and thirst, but the patient finally died. Hale recommends for spasms of the epiglottis gelsemium in physiological doses until the patient could not drink.

In conclusion I would say that lyssin has been used successfully in chronic headaches, epilepsy, mania, bites of animals, tetanus, longings of pregnancy, salivation, puerperal convulsions, prolapsus uteri, chronic diarrhœa, hysteria, angina pectoris and chlorosis.

MASSACHUSETTS AIR IN THE TREATMENT OF PHTHISIS.

BY HERBERT C. CLAPP, M. D., BOSTON, MASS.

It is not my purpose in this paper to attempt an exhaustive discussion of the subject, but merely to say a few words in support of the proposition that the air of many portions of our good old Commonwealth, *when properly used*, will cure a percentage of cases of consumption which will greatly surprise those of our physicians who are not acquainted with the *remarkable* results attained by the modern sanatorium treatment of the disease in Germany and some other countries whose climate is no better than that of our own State; and also that it is, when properly used, much more effective than the air of many famous climatic resorts when not properly used.

It has become the fashion with many of our consumptives who can afford it (and with some who really cannot and ought not to afford it) to go to Colorado, New Mexico, California, the Carolinas, etc., much as they would go on a pleasure excursion, trusting for their recovery entirely to the fact that they are sojourning in certain geographical regions, and magnifying the influence of the climate to the neglect of many hygenic and medicinal influences which are far more important. Many of them do not realize the necessity for medical attendance and the strictest supervision of all their habits, the amount of exercise each case requires, the amount of rest, the very important items of diet regulation, bathing, and other sanitary measures. Indeed, I am sorry to say that not a few even of our physicians virtually, if not actually, tell them that these things are comparatively unimportant, and that any kind of life in that particular locality—that locality which

has a reputation—will restore them to health, if anything will. The result, as we all know is in many cases extremely disastrous ; and if now and then a patient, with more than usual common sense and judgment as to the regulation of his own habits, does recover without proper supervision, it is but the exception which proves the rule. Undoubtedly many of these climatic resorts of reputation, especially those of some altitude, if in them the necessary comforts of life can be obtained, and when there can be a proper supervision of details, are very effective; but those physicians who have studied most into the subject now agree that the benefits of climate *in itself* have been exaggerated by most people, and recognizing the fact that almost as good results with proper restrictions have been obtained in the most diverse climates, many of which formerly had no reputation whatever in this line, have been forced to this conclusion: *That there is no specific climate for the cure of consumption, and that the only really essential requisites for it are that the air shall be pure and bracing, and such as to allow the patient to spend most of his day out of doors, and to have in his bedchamber plenty of it in its freshness at night.* This can be done in Massachusetts and in many other places.

It has been the experience, perhaps, of the majority of physicians that consumptives who have been cured in Colorado and other distant places will stay cured if they continue to live in those places, but will often relapse if they attempt again to live in the East; whereas it has been found that those who have recovered here, in or near the region where they expect to live and work for the rest of their lives, far more frequently find their cure permanent.

As a result of the sanatorium treatment at the institution at Goerbersdorf, Germany, statistics have been published which extend over eleven years and include 5,032 patients, showing eleven per cent. entirely cured, and fifteen per cent nearly cured. At Falkenstein from fourteen to fifteen per cent were entirely cured, and nearly as many "comparatively" recovered, while a large number of others were benefited more or less. Other sanatoria, in this country and abroad, report similar results, and some better still. Of course, *the earlier the stage of the disease, the larger the percentage of cures.* If only incipient cases are taken, the outlook is quite encouraging; and the enthusiasm generated by those who have become acquainted with these methods in almost any climate is remarkable, considering the wide-spread despondency which has held fast in its grasp for so many years the profession and laity alike. I believe with Weber that "there is nothing more baneful than the idea that consumption is incurable. It shuts out all honest attempts to do everything possible, and to make every sacrifice to promote arrest and cure." Fortunately, the profession is now becoming aroused to the conviction that many cases of consumption are cureable, even if they are unable to go to the ends of the earth. Phthisis is cureable everywhere.

Now what are the principal hygienic measures which have been so successful, and which can be more readily utilized in sanatoria than in private practice, because the patient is constantly under observation and discipline? They are in brief, *hyper-aeration*, or as near perpetual life in the open air as can be secured, the air being as pure, as free from dust and smoke and from micro-organisms as possible; *hyper-alimentation*, or plenty of good, sensible, nourishing, digestible food, given in the right way and adapted to each patient; the judicious employment of *rest* or *exercise* (especially rest), carefully adapted to each one's requirements and regulated from day to day (a tremendously important factor), and proper *bathing*.

To speak here only of the first, and that very briefly: some will say there is nothing new about that. We have all of us always heard of the necessity, for sick or well, of good ventilation and plenty of fresh air, and some physicans will doubtless solace themselves with the idea that they already make use of it. But the modern open-air treatment does not mean the three thousand cubic feet allowed each individual merely, but literally one hundred times more. It means the exposure of the patient to the open air from seven to twelve hours every day in almost all weathers, in summer and winter, on some kind of piazza or shelter, and protected from the rain and wind by various devices. At night abundant ventilation is secured by windows more or less open, according to the season. By day the patient reclines on a long chair, well protected by warm clothing, if necessary even steamer rugs and furs, or hot-water bottles being brought into service. The acclimatization has to be gradual, especially for those who are not used to fresh air, but after a while he gets toughened to it. At first also there is often much prejudice against it to overcome, and especially the fear of taking cold; but these soon yield when the fever subsides, the appetite and weight improve, night sweats lessen, and good sleep returns. Cough may at first increase, but soon diminishes, and it does not take long for the patient to become an ardent advocate of the treatment.

For the carrying out of these measures for poor consumptives and those in moderate circumstances the State of Massachusetts has just completed a fine hospital for two hundred patients, with a southern exposure and admirably adapted to its purpose, on a lot of over two hundred acres, on a hill top twelve hundred feet above the level of the sea, and commanding a grand view of the surrounding country for miles. Princeton and Mount Wachusett are close by, and Mount Monadnock is in clear sight. A beautiful lake one mile long borders the grounds. The hospital is furnished with a new supply of fine town water, and has good plumbing, heating and ventilating apparatus It is blessed with purity of atmosphere, free from malarial influences, presumably also relatively free from pathogenic microbes, especially streptococci, which cause so much of the mixed infection which adds

to the terrors of the plain tubercular infection, and last but not least, it has arrangements for the open-air treatment. On the grounds and directly in front of the hospital is a tree which by topographical surveys marks the exact centre of the State, north and south and east and west counting Cape Cod. The distance from Boston, which is practically the centre of the population of the State, is fifty-four miles on the Central Massachusetts Railroad, a ride of two hours only. This, so far as I know, has the honor of being the first State sanatorium for consumptives on this continent. Doubtless other States will soon follow our lead. It is not intended for hopeless cases. There is certainly a great demand for a *home* (not a *hospital*) for this class of patients. But it is perfectly obvious that if the Rutland Hospital should accept this class, it would speedily be filled to repletion, and prevent the admission of curable cases. If we can get them *early* enough, we expect that a respectable portion of them will be cured. We all know how hard it is to cure even early cases among the poor and ignorant at their own homes. The vast majority of them become incurable, not having the money or the will-power or the intelligence to carry out proper directions. Therefore I desire especially to urge upon you all the desirability of sending patients as early in the disease as possible, making the diagnosis either from a physical examination of the chest, or from a microscopical examination of the sputum, or from both.

Private patients of means or in comfortable circumstances, if favorably situated, can often be treated at home, if the physician is willing to give sufficient time to it, but the treatment of poor people at home is very discouraging.

The Massachusetts Homeopathic Medical Society, as a society, is to be congratulated that the State of Massachusetts offers in its Rutland Hospital the system of medication in which we believe, as well as the regular treatment of the old school. Undoubtedly the success of the Westborough Hospital has contributed in no small degree to this consummation, and it is hoped that the success of this new institution may be sufficiently marked to induce future Legislatures to enlarge our sphere in other directions. But we can expect no success unless each individual member of the Society will take enough interest in the matter to send curable cases; and patients in the early stage are notoriously unconcerned, and often need to be aroused from their lethargy and urged to action. It is no kindness to such a patient to conceal from him his condition, unless, indeed, we can offer no remedy. But if we think we can put him in the way of recovery, it is certainly our duty to enlighten him, in order that he may intelligently coöperate with our means of cure.

No Massachusetts consumptive need be refused on the ground of expense. The charge of fifty cents a day, established by the trustees, to cover everything, is certainly less than the patient could be cared

for at home; and in case he is too poor to pay even this, the town or city where he has a settlement will pay it for him, or some other provision can be made. But be sure to send him *before he is far advanced in the disease.*

DISCUSSION.

Dr. E. P. Colby, in discussing Dr. Clapp's paper on "Comparative Strength of Tinctures," said that it was so excellent there was very little required in discussion, but he wished to call the attention of those present to two important facts which had been mentioned. The first was that by the use of this Pharmacopœia of the American Institute of Homeopathy we now had a uniformity between the triturations, tinctures or other preparations, all of them representing an equal value of drugs. Some physicians prefer one form of pharmacal preparations, others another form; but no matter what form is used or preferred, there was no deviation in the slightest degree from the original drug strength.

The second point to which he referred was the statement made by some that this book deviated from the strength of Hahnemann's tinctures. He thought this was a misstatement, and that this work came nearer to this standard than any other we had. Hahnemann said that in the preparation of the dry drug into the tincture there should be used a proportion of one part of the drug to ten parts of the menstruum. This was practically his typical tincture. Now, this was exactly what this committee had recommended in every possible instance, namely, that the drug, no matter how wet it was, should be reduced by estimate to the dry drug, and then in the proportion of 1 to 10 it should be so used. The reduction is simply one of estimation, and when once made any pharmacist or even the physician himself can go on making the drug to the full standard of 1 to 10, whether it is in the wet or dry form. So that in fact we were getting a stronger tincture, rather than a weaker one, than in the old-fashioned hit-or-miss way.

Dr. Fred. B. Percy said that he wanted to recall to the members of the Society that it was hardly possible to estimate in words the amount of time and the energy and worry which had been given by one of their number to this work, and he wished to move that the Society here to-day endorse this work.

Seconded by Dr. Boothby, and carried unanimously.

Dr. Frank C. Richardson, in opening discussion on paper entitled "Notes on Apomorphia," thought the doctor had made a very successful and legitimate prescription, and left very little to be added to the paper. He had found the drug very useful in spastic conditions, and in physiological doses an excellent antispasmodic. Had used it

very successfully homeopathically for vomiting and nausea. It was very serviceable in spasmodic asthma, and had used it in a number of cases with almost invariably good success. In regard to dosage, that would depend of course upon the effect we wanted to produce. One-twentieth of a grain works very well as antispasmodic, and on the other hand he had had good results in dissolving one-twentieth of a grain in one-third of a glass of water, and giving in teaspoonful doses, for the relief of nausea and vomiting. He thought it a reliable and useful drug. Used it very frequently in hypodermatic form. It was not a specific for vomiting of any sort, but it was thoroughly and truly homeopathic to certain states of nausea and vomiting. While not prepared to clearly define the range of action, he would suggest its use where the action was markedly spasmodic, with continuous and violent retching. Other remedies failing, should use it without this indication, but the condition of spasm had been his indication hitherto. Physiological doses produce relaxation.

Dr. J. T. Sherman referred to a case of severe spasmodic asthma, occurring in the night, where, after some hours of suffering, the hypodermic use of apomorphia, one-eighth of a grain, produced prompt emesis, and relief to the asthma at once. Was able to go to business the next morning.

Dr. M. P. Wheeler referred to a case where the third decimal trituration tablet, in one grain doses, promptly relieved the vomiting, which had been severe and persistent.

Dr. J. W. Hayward said he had once given it to a patient to take with her on a sea voyage, who, on her return, stated that it not only relieved her, but a number of others.

Dr. F. A. Davis knew of a case of a young woman who had attempted suicide by taking one ounce of laudanum, where the drug was given in one-fifth of a grain hypodermically, which produced vomiting within three minutes, and the patient retched for ten hours afterwards.

Dr. F. C. Richardson wanted to give a word of caution about its use where there had been previous cardiac weakness, or where great depression existed, as the reaction from the drug was at times very severe and alarming, almost collapse in some cases.

In discussing paper by Dr. H. C. Clapp on "Massachusetts Air in the Treatment of Tuberculosis," Dr. F. B. Percy said there was very little to add to the paper. Every physician was invited to visit the

place, and see for himself as to the location and the possible good coming from it. He had only a word to say in regard to the treatment of tuberculosis in sanatoria. We all knew of Dr. Bowditch's work in Sharon, and the good accomplished. In New York State there were two institutions, one at Saranac, under the charge of Dr. Trudeau, and the other at Liberty. These were private institutions, and the hospital referred to by Dr. Clapp was the first attempt in this country, and, so far as he knew, in any country, to provide a place where tuberculosis can be treated in the earliest stages, with the probabilities of curing the young men and women, and sending them back home to be useful and working citizens.

It was necessary for the trustees and medical board to make rules which seemingly are very stringent, but it is only seemingly so, for if we consider what the results would be if all tuberculars were admitted, everyone must admit the wisdom of the action. This was the first time in the history of State institutions where we had an equal representation of the medical board, and it behooved every member of the Society to aid in every way the man who had been chosen to represent them, so that we might at the end of the year point with pride to the work done.

REPORT OF COMMITTEE ON OPHTHALMOLOGY, OTOLOGY, RHINOLOGY AND LARYNGOLOGY.

T. M. STRONG, M. D., *Chairman.*

I. Traumatic Puncture of the Sclero-Corneal Junction. George A. Suffa, M. D. Discussion opened by J. Miller Hinson, M. D.
II. Complications after Cataract Operations. August A. Klein, M. D. Discussion opened by John H. Payne, M. D.
III. Ocular Manifestations of Syphilis, with Clinical Cases. J. Miller Hinson, M.D. Discussion opened by L. Houghton Kimball, M.D.
IV. Keratometry and Astigmatism. David W. Wells, M. D. Discussion opened by George A. Suffa, M. D.
V. An Interesting Symptom. Howard P. Bellows, M. D.
VI. Complications Following Cataract Operations. Frederick W. Payne, M. D.

TRAUMATIC PUNCTURE OF THE SCLERO-CORNEAL JUNCTION.

BY GEORGE A. SUFFA, M.D. BOSTON, MASS.

This case that I offer for your consideration has much of interest to the oculist, being unusual in many of its features, instructive, and offering food for thought, not only to the specialist, but also to the general practitioner. This, I trust, would be sufficient reason for presenting the case at this meeting even if modern text books described injuries in this region properly. But such is not the case. Injuries in this region, if mentioned at all, are treated in a very off-hand way, no detailed treatment being given. It is for this reason that I have entered into detail in this case.

Master Rosenburg, aged six years, was brought to the Dispensary, March 14th 1898, the day following a peculiar and, I think I may say, a very rare injury to his left eye — not having seen a parallel case in medical literature — while playing with a companion. The latter was tossing into the air a piece of rusty iron, ten inches long, one-half inch wide, three-sixteenths of an inch thick, pointed at both ends, and to all outward appearance septic,— the location of the boy's home, the thickly settled tenement district of Harrison Avenue, would strengthen that belief. This piece of iron was not thrown more than ten feet into the air. In its downward course one point came in contact with the inner sclero-corneal margin, penetrating the tissues, tearing away the inner quadrant of the iris and rupturing, at least, the anterior

capsule of the lens. The point engaged the outer pupillary border of the iris, pushing it into the cornea about three millimeters from the outer margin and probably causing a fine perforation at this point, in which the iris was held. Then, either rebounding, or by its own weight, it dropped to the ground, followed in all probability, by the aqueous humor, the inner quadrant of the iris and the greater part of the lens substance with, possibly some vitreous humor — portions of the last three being grasped in the wound.

This prolapsed mass was of considerable size, being one-eight of an inch in thickness and covering the inner third of the cornea. It was freely moveable except where held between the lips of the wound. A probe passed readily under the mass to the wound which was firmly closed, so that the anterior chamber had refilled with aqueous, in which a small amount of opaque lens substance could be seen. The cornea and the aqueous were perfectly clear, no signs of foreign matter nor of hemorrhage being present. The tear in the iris was clean cut. No traction was exerted by the prolapsed portion in the angles. On the contrary, the outer pupillary border, which was adherent to the outer portion of the cornea, as already described, caused slight traction in the opposite direction. There was marked distortion of the corneal surface due to the compound injury. Reaction was no more than is usually seen the day after an incision of equal size has been made in this region with an aseptic knife. The fundus could not be clearly seen on account of the opaque lens substance. In two days this lens matter had become absorbed, when no lesion could be discovered at the fundus.

With the exception of marked disturbance of vision, due to the absence of the lens and the distortion of the cornea, there were few subjective symptoms. There was no severe pain immediately following the injury, but during the first night severe pain was complained of for about an hour, and again on the third night. Other than this, there was no complaint except of marked photophobia when the eye was exposed to bright light during the examinations. Fingers could be counted readily at three feet.

No operation was attempted, the treatment throughout being that termed expectant. The eye was thoroughly flushed several times a day with a saturated solution of boric acid. Sulphate of atropia was instilled twice a day for three reasons:

1st. If possible, to tear away the anterior synichia.

2d. To place the iris and eye in a complete state of rest.

3d. To contract and deplete the remainder of the iris in order to prevent inflammation.

Aconite was given internally for the first few days, every hour, to check excessive reaction, and the eye was bandaged between the boric acid flushings. Meanwhile close observation of the eye was kept, awaiting developments. Under this treatment the wound healed quickly. Contraction of the prolapsed mass and the healing of the

wound went hand in hand, so that within two weeks complete union of the wound and removal of the prolapsed tissue had taken place, only slight pigmentation remaining in each angle of the wound.

Several questions naturally present themselves at this time.

1st. What danger, immediate and remote, was the injured eye and the ocular system exposed to ?

2d. Would it not have been as well, or better, to have removed the prolapsed mass immediately, which nature could only do in time ?

3d. Why was it necessary to institute any treatment when nature did so much towards recovery ? Would she not have done the rest equally as well alone ?

The immediate danger to be feared most was septic infection with all its concomitants, and that an eye injured in this way with such a villainous looking instrument could escape such a calamity seemed improbable. There was also some danger of sympathetic ophthalmia within a few weeks and a lessened danger later.

The second question will be answered by stating that the course was chosen by careful deduction. In the first place, the lips of the wound were in such close apposition that nothing could have been gained by excising the prolapsed mass; the anterior chamber was reëstablished; the aqueous clear, with the exception of the small amount of opaque lens substance; the tear in the iris was clean cut, and no undue traction was being exerted thereon; the cornea was perfectly transparent, and no undue traction was manifest in any way. The prolapsed mass in no way interfered with healing. On the contrary, it aided by protecting the wound. Whereas, if the mass had been excised and an attempt made to clear the angles of the wound, the anterior chamber would have been reopened, with the loss of the aqueous, and perhaps an increase in the prolapsed iris. Moreover, if the patient had become unruly, a loss of the vitreous was to be feared, and the last state would have been worse than the first, especially as it would in no way have removed infection, if already present, or lessened the danger. In fact, it could only have increased the danger, as there would have been created a freshly denuded surface, ready to take in germs, a condition to be avoided, as the patient's surroundings were of the worst. The danger of sympathetic ophthalmia could hardly have been lessened by attempting to clear the angles of the wound, as the iris tissue in the angles was not of sufficient amount to have been readily removed, being closely grasped, if not already adherent, in the wound. Considerable interference would have been necessary, with probable failure of removal.

In answer to the third question, we can most emphatically say it was absolutely necessary, not only to keep the case under close observation in order to immediately detect complication, but also to see that the eye was freely and regularly irrigated and the atropia properly instilled.

COMPLICATIONS WITH OPERATIONS FOR CATARACT.

BY AUGUST A. KLEIN, M. D.

Hippocrates recognized cataract as a disease of the crystalline lens, and Latherius and Antillus operated for cataract in the first century. The teaching of Galen, that the lens was the organ of sight, brought the operation into disgrace, so that it was not resurrected till 1656, when Lasnier revived the truth. In 1708 M. Petit removed the lens from a clergyman with success. May, Wenzel and Petit were the early operators, but the operation did not gain much ground till Freytag made it prominent. M. Daviel published a work on cataract operations in 1747. After him Beer, Richter, Ware and Graefe added materially to the perfection of the operation by their inventions of new instruments. In later years we have such a great number of prominent operators that it would take a long time to name them all. Helmholtz added to the diagnoses of cataract by inventing the ophthalmoscope.

Before operations for cataracts came into general practice, cataracts were treated by external applications, as well as specific internal medicines. Among external applications we find setons in the neck a favorite remedy. Scarifications also stood high as a cure. Bleeding was considered a specific, provided it was often repeated. Blisters also played a prominent part, so did fumigations. Mercury was a regular bonanza. Among other cataract specifics we find eyebright, millepede, wildpoppy, henbane, hemlock, etc. Most of these remedies have lost their virtues as cataract specifics. New remedies and new methods have supplanted them. If one reads the advertisements in some of the daily papers, as well as in some of the medical papers, of the remarkable cures made by the absorption method, or by some of the specific cataract remedies, he may well wonder why such fools ever existed as to cut out a lens or to submit to an operation fraught with danger.

"The public wants to be humbugged" is an old saying. This holds particularly true as regards absorption of a cataractous lens and of specific medicines. Remarkable cures are often advertised; but if these cures are investigated, they are invariably found to be a humbug, or that the affection was no cataract at all. I doubt if any oculist ever saw a senile cataract disappear. I, for my part, never have. It is just this class of patients that patronize these absorption professors. Opacities on the capsule of the lens have now and then been absorbed, especially if the deposit was due to an injury, exudation, hemorrhage, iritis, etc. We often see pigment deposits on the anterior capsule from iritis disappear with or without medicines. I am sorry to say that many physicians cannot diagnose a real opacity on the lens from an inflammatory product deposited upon the anterior capsules. The

disappearance of such a deposit by absorption usually constitutes one of these remarkable cures.

That a cataract can now and then be checked in its progress is a well established fact. We all know that the primary cause of the opacity of the lens is an impaired nutrition of that organ. Any medicine that will assist to keep the more delicate organs of the body in a normal condition will also assist to keep them properly nourished. No organ in the body will suffer more or quicker from improper nutrition than the eye. Every practitioner has had cases where temporary impaired vision set in after loss of blood or an exhausting disease.

There are three methods by which an opaque lens is removed from the visual axis: Depression, that is, pushing the lens into the vitreous humor out of the visual line; discission, principally used in soft cataracts; and extraction, for all hard cataracts. Depression was first practiced by Gleixze, who published a book on that subject in 1786. Discission was first practiced by Couradi. Extractions were made popular by Freytag, Daviels, Beer and Graefe. There are various methods of extractions, usually named after the operator who first practiced that method. Thus we have Beer's, Graefe's, Yaeger's, Liebriech's, etc. Every operator seeks to perfect himself in his own method of operating.

It is not the scope of this paper to give a description of the various methods, but simply to call your attention to some new experiment in the treatment of Complications resulting from an operation, no matter what method has been adopted. One of the most disastrous accidents during extraction of cataract is the loss of vitreous. While a small amount may be lost without any evil consequences, the loss of the greater part results in blindness. There are various causes,— luxation of lens, fluid vitreous, tense sclerotic,—which will be predisposing to loss of vitreous during an operation. One of the most frequent causes is the spasmodic contraction of the lids by the patient. No wonder operators will lose their temper now and then. I saw a professor in a German hospital box his unruly patients right and left, till from sheer fright they kept still. Vitreous will escape sometimes as soon as the cornea is cut; in other cases it follows the capsular incision; again it is forced out with the delivery of the lens. Many times it is forced out by the patient during delivery of cortical substance, and in some cases after the operation has been completed and the corneal incision is finally inspected. I witnessed such a case in Schweiger's Clinic. Everything was completed; when the final inspection was made the patient squeezed his lids together, and out spurted the vitreous. Such accidents are likely to happen, and mostly when you least expect them.

The loss of vitreous leads to separation of the retina and shrinking of the eyeball. Many experiments have been made with artificial

vitreous, made of silver or gold, so as to retain the shape of the globe, but with little success. Experiments made on dogs seem to promise success, but when the hollow silver capsule was tried on human eyes it had invariably to be removed for fear of sympathetic ophthalmia. Recently the introduction of the vitreous of an animal has been tried with remarkable success. If I remember right, it was an English operator who used the eye of a sheep for that purpose, claiming that his patient's vision suffered but little by the substitution of the animal for the human vitreous. The technique of the operator was not given. Should the use of animal vitreous be successful, we will certainly hear more about it. Perhaps some of the members may have witnessed the operation. If so, I hope they will give us the benefit of their experience. The use of the animal eye is nothing new in ocular surgery. The substitution of the cornea of the rabbit for an opaque human cornea has been repeatedly tried, but with little success. But I cannot find any history for substituting an animal vitreous for a lost human vitreous. The experiment certainly merits a trial.

The vitreous is frequently lost during operation for secondary cataract. This will not happen if the secondary cataract is due to bands stretching from the remains of the edges of the cut anterior capsule. These bands are easily cut by two needles under reflected illumination. The danger comes when the posterior capsule is opaque and made dense by deposits on its surface, or when the solid ring formed by the edges of the anterior capsule being united to the posterior capsule, including lens substance, approaches more and more toward the pupil. In these cases it becomes necessary to remove the whole or part of the capsule, so that there is nothing to prevent the vitreous from entering the aqueous chamber. To stop the expulsion of the vitreous, all operative measures are abandoned, a compressive bandage applied, and rest imposed. Protruding vitreous is snipped off with scissors. The pressure of vitreous in the corneal wound is likely to retard a quick union of the edges, but as a rule the secretion of aqueous will force the vitreous in its place, so that little will remain in the corneal wound. The greatest danger of protruding vitreous lies in its danger of becoming the seat of infection.* Schweiger considers the vitreous an excellent breeding place for bacteria. The great percentage of purulent infiltration, — 2% to 3% of all cases operated upon, — shows certainly that the eye is a good place for the propagation of bacteria. While Schweiger considers the vitreous as the seat of infection, others claim that the corneal wound, or the iris, becomes first attacked. Infiltration shows itself first by a muco-purulent secretion on the dressing, corresponding to the palpebral fissure, a grayish opacity behind the pupil, the lids become puffed up.† There may not be the slightest pain connected with the

* Vide Schweiger.
† Vide Noyes.

process. The eye may be destroyed without the patient knowing anything about it. If purulent iritis or choroiditis is complicated with the process, severe pains will exist. The proximity of the tear passages has a great influence upon the high percentage of infiltration. Bacteria can travel through these passages and get under the dressing. This is greatly feared, so that some operators open the lachrymal sac from the outside* and insert an iodoform pencil in all cases of purulent inflammation of the lachrymal passages. Others go still further; they will obliterate the sac before operating for cataract, if the nose or tear passages are in a chronic state of ulceration. Other authors† claim that the tear passages become clogged or plugged up by the thick muco secretion, which they claim always occurs in cataract operation, so that infection from the nose does not occur as frequently as has been claimed.

All operators, no matter what opinion they may have as regards the cause of the affection, take the greatest care to prevent it. Unfortunately, the eyeball cannot be as thoroughly disinfected as other parts of the body. It is too delicate an organ to be scrubbed, and cleansed, and washed with strong antiseptics. The same holds true with the instruments used; they are too delicate to be scrubbed much. Nevertheless oculists try to make them antiseptic by boiling them in carbolized water before the operation, spoiling the temper and making them useless for further operations.

Disinfecting the eyeball is mostly done by washing the conjunctival sac with previously boiled water or a weak solution of corrosive sublimate, or a solution of boracic acid. Some of the authors strongly object to the sublimate solutions, stating they will cause partial infiltration of the cornea, although infiltration of the cornea wound is invariably treated by brushing a solution 1:500 of sublimate over the infiltrated wound. The anti-phlogistic treatment has always been favored. In order to prevent infiltration, Guthrie would bleed his patients two hours after the operation, and if any signs of swelling or pain would appear, he would bleed again; and if this did no good, more bleeding was done. Leeches took the place of the lance; ice takes the place now-a-days of both leech and lance, not with the former idea to check the blood current in the infiltrated wound or to keep the unclean blood away from the wound, but to prevent the development of bacteria. Bacteria will not develop under a certain temperature, although their spores or eggs, as you may call them, can stand a very low temperature and still develop into bacteria when brought into higher temperature and proper nourishing substance.

Since the vitreous is an excellent nourishing substance, and the temperature of the eye under the bandages is favorable, an ideal condition exists for developing cultures of Bacteria. So long as the

* Vide Schweiger.
† Kuhut.

blood current is in a healthy condition it can send enough corpuscles to the wound to destroy the living bacteria; but if these bacteria are too numerous or remain too long in the wound unmolested, they will deposit their spores which cannot be attacked by the white corpuscles. These spores then develop into bacteria in such great numbers as to destroy the eye. The fallacy of blood letting is more and more recognized by eminent operators. Instead of drawing blood away, it is stimulated to greater activity by hot applications in the beginning of infiltration, with the object to destroy living bacteria, as fast as possible, before they have time to deposit spores and develop. This stage has to be carefully watched. If hot applications do not reduce the swelling and discharge within twenty-four hours, ice should at once be applied and all bacteria destroyed with sublimate, as far as they can be reached. If fibro-purulent deposits have formed in the anterior chambers, they must be removed with forceps, and the chamber washed out with sublimate, 1.5000;* should the whole eyeball become involved, the timely emptying of the scleral sac or enucleation, will prevent sympathetic ophthalmia or purulent meningitis. Of internal remedies we must give such as will assist the nervous and circulatory and absorbing elements. Ars., Acon., Iod., Hepar., Kali Bi., are favorable remedies. Hepar Sulphur, which is so often sneered at by some surgeons, has a calcifying effect upon spores. It forms a sort of shell round them making them incapable of development. The only trouble is, that we do not give enough of it. If given too low, its action is like all strong medicines, it will not be carried by the circulation. I usually give a pill of 3x every hour with good results.

Iritis, cyclitis, choroiditis, are diseases which are likely to follow cataract operations. The liability of the iris to prolapse or injury is always an item of great concern to the operator. It is the first accident liable to happen. The iris is prone to fall over the edge of the knife as soon as this enters the anterior chamber; if this happens, pressure is made with the finger above the knife; this will cause the iris to fall back. Should it happen that the iris becomes transfixed, we must either withdraw the knife or push boldly on and complete the section. The prolapsed part of the iris is then cut off and the angles smoothed out before delivery of the lens. To prevent this accident as well as to prevent the iris from being bruised, iridectomy is performed, sometimes long before the lens is removed. In later years linear extraction without iridectomy is preferred by many. It is claimed there is less liability to iritis than when an iridectomy has been made.

I treated one of the worst cases of cyclitis, following a cataract operation, without iridectomy, made in one of the public institutions in Boston. The eye was sensitive to the slightest touch for over a year. The great danger of prolapsed iris is, that it may become the

* Noyes.

seat of infection, leading to all the destructive complications mentioned above. If this takes place, the eye has to be treated similar to purluent infiltration. A prolapsed iris after delivery of lens, is replaced through the corneal wound; but if the accident happens later, the prolapsed part is snipped off with a pair of scissors. Mild cases of iritis easily yield to atropine and hot water. A lotion made of three drops of tincture of aconite to a cup of water, and applied with soft cloths will often assist the cure. Aconite is one of the best remedies, internally and externally, when the condition calls for it that is, in the first stages of iritis. Combine with aconite the stimulating effect of hot water, and the majority of cases of iritis will yield. Cocaine is a necessary adjuvant if pain is present. As soon as iritis turns into purulent infiltration hot applications are dangerous, and must be substituted by ice; aconite is also useless. Ars., iod. and hepar will have to be administered internally. A case of my own experience will illustrate this.

Patient male, 70 years of age, nervous temperament and well nourished, was operated for senile cataract on the left eye. Linear extraction with iridectomy was made and everything went well till the fifth day. The corneal wound had healed, there was not the slightest pain nor inflammation so that I permitted the patient to sit up and loosen the bandage. That night he dreamed something was biting him in the eye, so he pushed his thumb under the bandage to chase away whatever it might be. He awoke at once with severe pain in the eye. Calling the nurse, she removed the bandage and found the lids red and swollen. She immediately applied hot water compresses, but without relief. Next morning I found the lids so much swollen and tense, they could not be opened. Corrosive sublimate 1.5000 was at once ordered to be injected, as much as could be. Aconite internally, and hot applications continued, with the result that the pain, swelling and secretion grew worse; the case began to grow desperate. Ice was ordered; small pieces wrapped in cloth were applied all night; hepar. sulph. was given internally; cocaine with corrosive solution was injected between lids as often as possible. Next morning the swelling was so much reduced that the eye could be inspected. The corneal wound had been forced apart. The iris prolapsed at the inner angle of the wound. Conjunctiva highly congested, with muco-purulent discharge upon the lids. The treatment was continued for three days, when all swelling disappeared. Discharge stopped, but the conjunctiva remained congested for over three weeks. The patient's eyes and sight were saved. The success of the treatment was undoubtedly due to the ice applications and the antiseptic wash, while hepar sulph. unquestionably did its duty internally.

You will find in many books hypodermic injections of morphine to be recommended where severe pain exists. I have never used them.

I consider that morphine is injurious to the healthy action of the natural forces, by stupifying the sensitive nerves. You also stupify their action and prevent the stimulation of the individual cells for resistance.

Hemorrhage is a complication met with now and then. The blood may come from the conjunctival wound, and force its way into the aqueous chamber, or it may come from a wounded iris. It is always a disagreeable accident although not dangerous when from the iris or conjunctiva. If the lids are kept closed for a while it will soon stop and the resecretion of aqueous will assist in washing it out of the chamber; the accident will delay the delivery of the lens. It is different when the hemorrhage is intra-ocular. This is a most serious accident in which the eye is frequently lost. The blood comes from a ruptured retinal or choroidal vessel, mixes with the vitreous which in most of these cases is fluid, and is forced through the corneal wound. The accident is due to the sudden collapse of the sclerotic when the anterior support is removed. The treatment consists in stopping all operative proceedures, applying of compressive bandages, absolute rest and internal medicines, to assist in the absorption of the blood.

OCULAR MANIFESTATIONS OF SYPHILIS, WITH CLINICAL CASES.

BY J. MILLER HINSON, M. D.

Time will not permit, neither is it the purpose of this paper, to enter into a detailed description of the many specific eye troubles. I wish merely to bring to our notice the ocular complications we may expect as a result of syphilitic infection, and at the same time to lead up to the report of two cases which I wish to present.

Syphilis is the cause of 75 per cent. of all eye diseases.

There is no tissue of the ocular economy which is exempt from its ravages. There is no stage of syphilis in which we may not have ocular lesions. It seriously affects the eye in both the acquired and congenital form, and permanent impairment of vision frequently results under the most skilful and scientific treatment. The lesions may not present themselves until at a period very remote from the active manifestation of the disease.

The most vascular structures, namely, the iris and choroid are the most frequently attacked. We will notice first the lesions of the lid taken in its entirety. Naturally, the first to occur to our minds is the primary sore or chancre, which, although not of common occurrence, is of sufficient frequency to warrant our consideration. Of 9058 extra-genital chancres reported by Bull, there were 1810 of the lip, 1148 of breast and nipple and 372 of eyelid; the smallest number, 27, being of ear; the largest, 1863, from vaccination.

The general characteristics are the same as of chancre elsewhere on the body. It may occur on the skin, conjunctival surface or lid edge. The virus probably gains entrance through the ducts of the Meibomian glands. The chancre usually begins as a small, painless pimple, with itching and irritation. The summit breaks down, becomes excoriated and hollowed out. The ulcer is rarely deep. The base is distinctly indurated. The conjunctiva is congested and there may be muco-purulent discharge. Neighboring glands are indurated.

Chancre may be confused with a broken down tertiary syphilide. Hordeolum or stye, Tubercular ulcer, Rodent ulcer, epithelioma and suppurating chalazion tumor caused by occlusion of Meibomian duct. The indurated base of chancre is of the greatest value in differentration. A *tertiary ulcer* or broken down gumma has not the indurated base; its edges are sharply cut or punched out. Floor bathed in pus, neighboring glands not indurated. Hordeolum or stye runs an acute painful course and heals quickly after opening. Suppurating chalazion has a narrow deep opening with soft edges, no induration, and the enlargement of the preauricular glands is an acute lymphadenitis, while the enlarged glands of chancre are sensitive only upon hard, firm pressure.

Rodent ulcer and epithelronia occur late in life and are very chronic. We may have enlargement of preauricular and submaxillary glands, with epithelioma, going on to suppuration as seen in a case recently. Juler states however, that before an epithelioma would cause glandular enlargement a chancre would have healed spontaneously and patient be half way through the second stage of syphilis. The Eruptions of syphilis occur on the lids as elsewhere, particularly on the skin surface, although very rarely they occur in the conjunctiva. We have also Gumma of the eyelid. Tarsitis, a general inflammation of cartilage and deeper tissues.

Syphilitic Catarrhal Conjunctivitis. Mucous patches, Ulcers.

The cornea is frequently the seat of syphilitic inflammation both in the acquired and congenital form, more particularly the latter. Until within a comparatively recent period it was not generally believed that acquired syphilis affected the cornea. I wish to mention only that form of Keratitis known as Parenchymatous or Interstitial. This disease occurs generally between the 8th and 15th year. Seldom in infancy and early childhood and rarely in adults. It consists of a more or less extensive diffuse haziness of cornea with areas of more dense opaqueness. There is usually a congested zone around the cornea with vascularity of the cornea itself. You will frequently find at some portion of the corneal periphery a crescentic shaped area of dense vascularity, of salmon color. The so-called salmon patch. With this condition there is often a peculiar hang-dog expression of countenance and the notched teeth of Hutchinson.

In the sclerotic or outer fibrous coat of eye we have a superficial

inflammation known as Episcleritis, a deeper involvement, parenchymatous scleritis and gummatous scleritis. Episcleritis, however, is more frequently of gouty or rheumatic origin.

The Iris.—This structure is the one most frequently attacked. Iritis from acquired syphilis is of three forms serous, plastic, papulous or gummatous, the last named being the only form pathognomonic of syphilis. The ciliary body is attacked by the same varieties of inflammation, in fact the two conditions are usually co-existing. It is unusual to find a cyclitis without iritis, yet we frequently have an iritis without a demonstrable insolvement of ciliary body.

Choroiditis and Retinitis.—Syphilitic inflammation of the choroid and retina is of frequent occurrence. As these structures are so intimately related we rarely if ever have an inflammation of one without involvement of the other. This disease results in impairment of visual acuity. If the macular region is involved the loss in vision is very decided. Reference to plates in any text book on eye diseases will show a normal fundus and also one showing results of syphilitic choroido-retinitis.

The white spots with black edges mark the seat of inflammation, followed by atrophy of choroid and retina with massing of pigment around edges of atrophic areas. Each spot is a blind area.*

The optic nerve may be attacked directly by syphilitic neuritis or we may have atrophy from syphilitic lesions exterior to and remote from nerve. One of the most frequent signs of later stages of syphilis is ocular palsies. A paralysis of a single muscle or group of ocular muscles should at once bring to our minds the question, is it syphilitic? The lesion may be Basilar, Cerebral or Orbital, occurring as to frequency in the order mentioned. Disease of the orbital portion of the nerve has never been reported and Bull states that "paralysis of the ocular muscles of orbital origin have been rather assumed to exist than actually observed."

Case I. January 25, 1898. Hattie M. Age 9.

Trouble with right eye, since one week. No definite complaint, only that eye bothered her. At time of examination no pain, profuse lachrymation, photophobia, *circum corneal* injection. No congestion of ocular conjunctiva, cornea, aqueous and vitreous too hazy to admit view of fundus. T—3, or in other words, the eye was so soft as to offer no resistance to palpating fingers. Hutchinson teeth, syphilitic physiognomy. In this patient there was involvement of Cornea, Iris, Ciliary body choroid and retina. Vision in right eye was reduced to counting fingers at from 18 to 20 inches. About ten days after first visit left eye showed evidence of beginning involvement and ran a course similar to O. D., although the tension was never lower than —1.

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* Reference to appropriate plates in any text book on eye diseases.

In March an acute arthritis of left knee with effusion developed. This was met by firm bandaging.

The extremely low tension of O. D. was the marked feature of case. The eye was so soft that at first I thought the damage was irreparable and the advisability of enucleation considered. Under atropine, Kali I. S. S. 25 gtts. t. i. d., together with merc. bin. or cor. as symptoms seemed to indicate there was immediate improvement in general condition of eye and a decided increase in tension toward normal. At date of last examination, Sept. 9, '98, there are marked choroido retinal changes at equator of eyes with some corneal haziness. Tn. o. u. b $= \frac{20}{60}$ without any lens correction, that is to say she can see a letter 1 inch square at 20 feet with either eye.

Case II. Lady, Age 51. Eight weeks previous to consulting me she awoke, found she saw "double," also that left upper lid had dropped and she was unable to raise it. On examination, May 17, '98, I found decided ptosis or drooping of lid, boptosis or protrusion of eye ball with marked outward rotation. Paralysis of ext. and int. rectus. Decided impairment in motion of eye in vertical axis showing involvement of sup. and Inf. Rectus. Pupil of left eye dilated and immobile, pupil of right normal. The only abnormality in right was due to paralysis of Ext. Rectus. In this case there was involvement of 3rd and 6th, and probably 4th nerve in left eye, and of 6th in right eye. Kali I, 15 grs. t. i. d., was prescribed.

Four months later I saw case again. In right eye Int., Sup. and Inf. Rectus had regained their normal tone as indicated by mobility of eye. The power of ex-Rectus was somewhat limited.

Left eye power of Ex. and Sup. Rectus somewhat limited. Int. and Inf. Rectus normal. The divergence of left eye being followed by convergence which was present. Pupils of both eyes normal in size and mobile. To a casual observer the eyes presented no abnormality.

KERATOMETRY AND ASTIGMATISM.

DAVID W. WELLS, M. D., BOSTON, MASS.

The value of the Javal ophthalmometer in the objective determination of astigmatism, being a subject about which such opposite opinions have been held, the writer determined on a series of experiments in order to settle the question, at least for himself. This series of test-cases was commenced in '92 under the following conditions:

Before taking the vision, or using the ophthalmoscope, or looking at the patient's old glasses — in fact with the refraction an absolutely unknown quantity — the keratometer was used on every patient and a record made immediately in the case-book in ink. The refraction

was then worked out objectively with the ophthalmoscope and subjectively with the test-lenses. This practice was followed till there were obtained records of 750 cases or 1500 eyes. The practical value of keratometry was so well established in the writer's mind that since that time this order of routine has been changed to first, testing patient's vision in each eye unaided; second, ophthalmoscopy; third, keratometry; and fourth, trial-lenses. This reserving of trial-lenses till the last is not the method usually practised, but it must be admitted that success in refraction work will be in direct proportion to one's ability to substitute the objective for the subjective method — to eliminate the personal equation of the patient. Dr. Jackson's announcement of a similar routine has been noted with interest in a recent publication. The common name of the instrument, ophthalmometer, meaning literally, an *eye* measurer, is altogether too comprehensive. This is simply a means of measuring the anterior surface of the cornea, just as though it were a convex mirror. By turning the arc two meridians are found which vary most in their curvature, that is, are of greatest and least refraction. The eye may be myopic or hyperopic to any degree, and the correcting cylinder be either + in one direction or — in the other direction, with the *same reading of the Javal.* Several years ago Swan M. Burnett proposed the name "Keratometer," as more logical and more in keeping with ophthalmological nomenclature. It means literally a measurer of the *cornea*, not the eye as a whole. It has a common stem, "keratos," with keratitis, inflammation of the cornea; keratoconus, an outward protrusion of the cornea; keratome, a knife for cutting the cornea, etc. But, it may be asked, "What's in a name?" The name "Ophthalmometer" has led to a misunderstanding of the scope of this valuable adjunct, and brought it into disrepute because it did not show whether the astigmatism be myopic or hypermetropic. The readings simply show the *difference* in refraction of two opposing meridians.

But this does not represent the total astigmatism. While the anterior surface of the cornea is the principal seat of astigmatism, yet there are other refractive surfaces which may and do enter in to modify the result. The posterior surface of the cornea may not be exactly parallel with the anterior. It may have an astigmatism. The lens is known to be the seat of astigmatism, which may be either dynamic or static; and if the latter, either from the irregular curve of its surface or from a tilting forward of the top. But, it may be said: "If the total astigmatism, which it is important to determine, in order to relieve your patient, be the algebraic sum of the astigmatism of the various refracting surfaces, of what practical use is it to know the error of only one of them, the cornea?"

Just this: Corneal astigmatism has been found to bear, in a majority of cases, a certain definite relation to the others, so that, *this* given, by a very simple rule the total subjective astigmatism may be approximately estimated.

As an average of the results of a large number of independent observers, Adolph Javal, Jr., has deduced the following table of corrections:

Corneal.....	..	1.00	2.00	3.00	4.00	5.00	6.00
Total.....	—.75	.50	1.75	3.00	4.25	5.50	6.75

It transpires that the normal cornea has an astigmatism of +.50 D. 90°, but the normal lens and other factors have a neutralizing astigmatism of —.50 D. 90°. This means that if the keratometer show an astigmatism of +.50 D. 90° (*i. e.*, "with" the rule), the eye as a whole is free from astigmatism, and if the Javal shows no astigmatism there will be found .75 D. "against" the rule, requiring either —.75 D. cyl. 90° or + .75 D. cyl. 180°.

When "with" the rule the difference between the corneal and the total gradually decreases as the astigmatism increases, till at 3.00 D. the two are identical, and above this amount the total gradually increases on that shown by the Javal.

Whenever "against" the rule the writers experience would indicate that .75 D. must be added to the corneal amount. He does not know if this is generally accepted, but in the results about to be given this rule has been adopted.

The tabulating of these statistics has taken so much time that of the 750 cases measured under test conditions, that is, an ink record made of the Javal results when nothing was known of the refraction, only 475 are included in this report. These have been divided into two sets. First, 420 cases, taken consecutively from the beginning of the test. In only 16 of these was a cycloplegic used, so that they may be fairly classed as a series *without* cycloplegia.

Whole number of eyes.....837.
Making corrections according to Javal's rule:
Keratometry and trial-lenses agreed.....274 = 31 per cent.
Keratometry and trial-lenses varied .25 D..303 = 35 per cent.
Keratometry and trial-lenses varied .50 D..159 = 19 per cent.
Keratometry and trial-lenses varied .75 D..108 = 13 per cent.

Series II. — *With* cycloplegia.

This includes the succeeding 50 cases, in which a cycloplegic was used.

The drugs employed were principally homatropine and scopolamine, atropia sulph. in only a few:

Whole number of eyes.....100.
Keratometry and trial-lenses agreed..... 34 = 34 per cent.
Keratometry and trial-lenses varied .25 D.. 37 = 37 per cent.
Keratometry and trial-lenses varied .50 D.. 24 = 24 per cent.
Keratometry and trial-lenses varied .75 D.. 4 = 4 per cent.

As might be expected, the results are a little better where accommodation was paralyzed:

Perfect agreement.....34 per cent., against 31 per cent.
Variation .25 D.....37 per cent., against 35 per cent.

The average vision of cases showing the larger variations is fully up to the others, so that failure is not due to amblyopia.

In order to determine the value of the method in the different degrees of astigmatism, the first series of 837 eyes has been tabulated under six divisions:

Whole number of eyes in which trial-lenses showed no astigmatism .....296.
Keratometry agreed in.....116 = 40 per cent.
Keratometry varied .25 D..... 65 = 22 per cent.
Keratometry varied .50 D..... 27 = 9 per cent.
Keratometry varied on average..... .33 D.

Whole number of eyes in which trial-lenses showed .25 D. astigmatism .....125.
Keratometry agreed in..... 19 = 15 per cent.
Keratometry varied .25 D..... 68 = 54 per cent.
Keratometry varied average..... .29 D.

Whole number of eyes in which trial-lenses showed .50 D. astigmatism .....142.
Keratometry agreed..... 70 = 50 per cent.
Keratometry varied .25 D..... 39 = 27 per cent.
Keratometry varied .50 D..... 31
Keratometry varied average..... .19 D.

Whole number of eyes in which trial-lenses showed .75 D. astigmatism .....69.
Keratometry agreed..... 18 = 26 per cent.
Keratometry varied .25 D..... 36 = 52 per cent.
Keratometry varied .50 D..... 12
Keratometry varied average ..... .25 D.

Whole number of eyes in which trial-lenses showed 1.00 D. astigmatism .....42.
Keratometry agreed..... 11 = 26 per cent.
Keratometry varied .25 D..... 14 = 33 per cent.
Keratometry varied .50 D..... 13
Keratometry varied average..... .30 D.

Whole number of eyes in which trial-lenses showed *more* than +1.00 D. astigmatism .....126.
Keratometry agreed..... 30 = 24 per cent.
Keratometry varied .25 D..... 41 = 26 per cent.
Keratometry varied .50 D..... 30
Keratometry varied average..... .28 D.

This would show that best results are obtained where astigmatism is .50 D., and this proved to be the *most numerous of the astigmatic cases.*

The comparatively large error in eyes with .25 D. astigmatism is to be deplored, as these lowest degrees are often productive of severe asthenopic symptoms.

Lest the rather poor showing in the lowest degrees should be prejudicial to the keratometer, comparison should be made with the untrustworthiness of direct ophthalmoscopy in the same field. Few oculists can read closer than .50 D., and yet one would not think of omitting direct measurement even if it were known that the astigmatism of a given case was less than .50 D. as brilliant results are often obtained, as well as important indications and verifications.

The determination of the exact *axis* of the correcting cylinder is quite as important as the cylinder itself and in this the reading of the Javal is very trustworthy. This is especially valuable, when one has to deal with a patient whose perceptions are not acute, and whose answers are unsatisfactory.

Another class of cases where this instrument has been of inestimable value is those with corneal opacities as a result of ulcers. These often have a high degree of astigmatism, and the improvement of vision is so slight that many of these patients have been passed as beyond help when tested by subjective methods only.

In most of these cases direct ophthalmoscopy is unsatisfactory, and without this *conclusive* objective measurement one would not feel justified in prescribing the strong cylinders 4.D. to 8.D., which are really often indicated.

The prompt and permanent relief of marked asthenopic symptoms in these patients has been so universal, that the writer *prescribes with assurance* on the keratometric readings even if a cylinder of 6.D. gives butslightly improved vision.

In using the instrument certain details require careful attention.

First, the patient's head should be exactly erect, the chin and forehead kept firmly pressed against the rests.

Second, the head should remain immovable till *both eyes have been measured.* This insures the correct relation of the axis to each other, even though the head be not erect.

Third, the instrument should be centered on the cornea very exactly, as peripheral portions show an aberration which is very misleading.

This is true of the normal eye, but the iris diaphragms off all but the centre.

In conclusion: Keratometry determines the correct cylinder in 34 per cent. of the cases. It varies only .25 D. in 37 per cent. more. It gives the axis in the great majority of cases very exactly. It determines the seat of astigmatism, whether corneal or lenticular.

When it fails it does *not* mislead, as the visual acuity test is a safe check.

It is now *possible* with elaborate apparatus to measure the astigmatism of both surfaces of the lens, and when this shall be made practical for routine office-work, the table of corrections may be dispensed with.

Undoubtedly many mistakes have been made both in measuring and in the recording as few of the cases were verified by a second reading, and for this some allowance should be made to the credit of the instrument. The infallibility of the test-lenses as the criterion may be open to some question, especially when a cycloplegic is not used. The personal equation of the operator should be given careful consideration. Yet the writer feels justified in *concluding* that no oculist can afford to neglect keratometry in any case.

Note.— The keratometer used throughout these tests is one of the first made by E. B. Meyrowitz & Co., and it is presumable that the newer models, with improved illumination, will enable one to read the fractions of a step with greater accuracy.

AN INTERESTING SYMPTOM.

BY HOWARD P. BELLOWS, M. D., BOSTON, MASS.

March 3, 1897, a young man called at my office complaining of a distressing tinnitus in the left ear. It developed two weeks previous to his visit to me, and had been an increasing annoyance ever since. There was no pain in the ear, nor any sensation of heat or of throbbing. The hearing power was practically unaffected. But when the rim of the ear was brushed by the hand it gave rise to an unnatural "woodeny" feeling in the ear; and a more decided touch of the hand, or the contact of the coat collar, occasioned a noise within the ear which my patient very graphically likened to "the bending of a piece of cloth which had been frozen." A rumbling sound, and, to again quote the patient's words, "a sort of rasping noise," was produced within the ear by simply walking across the room.

The examination of this patient's ear revealed the cause of the annoyance at sight. Held firmly embedded in a coating of wax upon the anterior wall of the meatus, near the isthmus, was one end of a cut hair, which was about one half an inch in length, and the other end of the hair was held thus in constant contact with the superior posterior quadrant of the tympanic membrane. The tinnitus was occasioned by actual movements of the free end of the hair

against the surface of the drumhead. After inquiry I learned that the patient's hair had been cut about the time the noise developed, and this bit of hair had probably been blown into the ear by the barber. Its removal by a pair of delicate forceps stopped the whole difficulty immediately.

This may seem a trivial case to report before a meeting of our State Society, but I present it simply as a text. The sermon will not be long, but the application, I hope, will be very obvious.

Does not the symptom, as presented by this patient, "a noise in the left ear like the bending of a piece of cloth which had been frozen," sound like many another symptom in our expanded and complex materia medica? Does it not remind us, for instance, of that other symptom which we find under eupatoreum purpureum — "crackling, like burning of birch-bark; very much increased upon swallowing anything"? Suppose that, either led by this similarity in the character of the noise or through lack of any better choice of remedy, I had simply administered eupatoreum internally to this patient, in any potency whatever, and sent him away with the assurance that in a few days the annoyance would cease. The prediction in that case would have proven perfectly true, for within a few days more, by the natural process of growth of the cutaneous lining of the external meatus, from within outwards, the hair would have been sufficiently withdrawn to no longer touch the drumhead. What a chance then for a real clinical verification! We might thus have had one more "verified symptom" in our materica medica.

It is not necessary for me to dwell upon this lesson. Its meaning is sufficiently plain. It means that every physician in the practice of medicine should have in his possession a suitable mirror and three or four specula for the examination of at least the external canal and the drumhead of his patients' ears. And furthermore, it means that the advantage of this will accrue not only to the patients themselves, but to the accuracy of our materia medica, of which we are so proud in spite of occasional errors and rambling prolixity.

Then, and not till then, shall we understand in our provings, with scientific accuracy, the meaning of symptoms like "crackling in the ears when moving jaws," "crackling in ears when reading aloud," "crackling in ears when eating," and "crackling in ears when chewing," symptoms which we find at present in the provings of seven different remedies, and which may or may not be of any useful significance whatever.

COMPLICATIONS FOLLOWING CATARACT OPERATIONS.

FREDERICK W. PAYNE, M. D.

Concerning the "complications following cataract operations" although multitudinous in form, and of any degree of possible seriousness in extent, my own experience in their treatment warrants the assertion that with the aid vouchsafed to us, that comes from the application of the *similimum* in therapeutics, many conditions that are ordinarily considered of complicating magnitude, and of profundity in extent, are almost invariably conducted quickly and gently into the paths of restoration and health, through the wonderful far-reaching knowledge permitted us, in the application of our great law of cure, formulated by the Master's mind, *similia, similibus curantur*, which, through its kindly and beneficent offices, convert silently and satisfactorily, many conditions of ill-health and alarm into the peaceful ways of strength and health.

In choosing cases for successful operations, a careful *diagnosis* in advance is imperatively necessary, that possible entangling complications in after-effects may be anticipated and thus avoided. Many cases resulting from choroidal disease, as well as those arising from affections of the deeper nervous structures and apparatus of the eye and its appendages, whereby the medium of transmission of the visual ability to the brain is involved, are notable cases that should be well recognized in advance, that false hopes be not raised in one's own or the patient's mind, as to a possible condition of *acuteness of sight* that *cannot* actually, in any way, be attained, howsoever well the cataract extraction may have been performed, and the recovery effected, for there are many cases having *little power* of visual acceptance, whether complicated with, or without the presence of an opaque lens. Among one hundred cases operated upon, was one of iritis; one of detachment of the retina; in a case of congenital cataract, with great fluidity of the vitreous; one of keratitis with purulent infiltration of the wound, occurring in an enfeebled old man, who developed septic symptoms, and died in a typhoid state; one case of panophthalmitis, after discission in secondary cataract, supervening upon a senseless exposure in a snow storm, immediately after the operation was performed; this patient, contrary to orders, departed for an adjoining state on the evening train, after having been operated upon in the morning, and, on arriving at his destination, about three o'clock in the morning, on a belated train, found a heavy accumulation of snow, through which he waded to his home, where he arrived, chilled, wet and exhausted; it seems unnecessary to add that he went through the horrors of intraocular abscess, and has now a beautifully atrophied bulbus oculi to show as a relic of his folly; finally one case of fistulous opening in the cornea, supervening upon a cataract

extraction, where a shred of iritic tissue was left at the angle of the wound; the aqueous fluid drained from this opening for three or four months, till cured by an operation for the purpose.

These one hundred cases were operated upon by Von Græfe's Modified linear method, all being combined with an iridectomy, excepting two cases, where the extraction was done without it, and all made a good recovery with the exception of the case of panophthalmitis, and that of the septicæmia, above mentioned. The case of detachment of the retina was reported several years ago, under the general heading of congenital cataract, but the conditions were so unique and of instructive and interesting a character, that a repetition concerning some of its essential points cannot be amiss, especially that pertaining to the aid received from the *similimum*, that converted an apparent failure into that of a glowing and triumphant success. As already reported the case was that of congenital cataract in a lady of middle age, whose only brother was similarly affected. She had been repeatedly discouraged by oculists, from attempting an operation as being hazardous and without promise of success, even as to the possibility of *partial* visual ability being attained; basing this prognosis, I suppose, upon the probability of the *acceptive* appendages of the eye being also *faulty* in construction as were those of the more superficial tissues; so, of course, in consequence of these already expressed opinions, she came to me with many misgivings concerning the accepting of advice favoring an operation. On careful ophthalmoscopic examination, however, combined with applied objective and subjective tests, I concluded that the eyes should be made to see, providing restoration from the actual operation upon the tissues could be made to follow in sequence, as a necessary accessory, so, correspondingly, advice and encouragement based upon this view of the possibilities in the case, was given her. All things having been explained she concluded to take the risk, and the several operations were made at intervals, as the subsequent events show. The right eye was chosen first, owing to the fact that it was the least good of the two, and as the several operations were to be experimental, it was only right that the chances of loss should be *risked* upon the *less useful* member rather than upon the better eye. With the right eye she could simply discern light from darkness, and all shadows between herself and the light were but dully seen, while with the left or better eye, she was *sensitive* to the presence of shadows, and had good acceptive ability in the perception of colors, when placed in a strong and favorable light for so doing. The first operation, done upon the right eye, was by the suction method; this was conducted under cocaine, first incising the cornea with a bent triangular keratome, and cutting the capsule of the lens, then by stirring up as far and extensively as possible, the substance of the disorganized lens tissue, and attempting its expulsion, as I have said, by suction; the opera-

tion was, however, in the main unsuccessful in its purpose, as I was only able to remove a small quantity of separated, tough, pasty cohesive material, which clogged the nozzle of the instrument, without clearing the pupillary area, so further efforts were for the time, discontinued, and the eye allowed to heal, which it did rapidly.

In a month following, the second operation was performed upon the same eye by means of Von Graefe's modified linear, combined with an iridectomy; the tough, shrunken, anterior capsule was incised, and the disorganized lens substance coaxed out by means of regulated pressure and counter-pressure, manipulating with the lids back and forth upon the globe toward the incision in the cornea, thus gradually causing the extrusion and escape of the broken-down lens substance. After the debris was entirely removed, it was found that the posterior capsule of the lens was occupied by a condition of complete calcareous degeneration, lime being abundantly present in its substance, and extending backward toward the *center* of the vitreous body, hence, notwithstanding the entire lens substance had been extruded, the visual acuteness was scarcely at all improved, and the operation so far would prove useless for purposes of vision, unless the capsule, with the calcareous concretions within its substance and behind it, should also be removed, so this procedure was determined upon as being necessary for the *attainment* of vision, howsoever hazardous the undertaking might prove.

Briefly, let me say that a small, sickle-shaped, blunt hook was chosen as the instrument to effect this purpose, and the eyeball was barely saved from collapse, consequent upon the profuse gushing of fluid vitreous, as the partition wall between the anterior and posterior chambers of the eye was torn away. An apparent complication occurred at this time, which gave rise to a fear that the coaptation of the corneal flap might be interrupted, owing to the unfortunate presence of some limey substance in the shreds of capsula tissue having been swept off the hook and retained at the angle of the wound in the cornea, as the instrument was hastily withdrawn from the eye; this haste in procedure was imperative, however, that the compress and bandage could be immediately applied, as an aid in *restraining* the *emptying* of the intra-ocular contents as the gushing of the fluid vitreous occurred. The eyes were now kept bandaged for the five following days, the roller simply being removed at intervals to bathe the eye with a weak solution of Calendula and warm water, while Calendula 30 x was given internally, chosen on account of the necessarily comminuted condition of the tissues; great soreness of the eyeball, and throbbing pains through it.

On the fifth day the eye was carefully examined, and the cicatrix seemed to be firm, and the limey substance disappearing. On the sixth day she could imperfectly discern the surgeon's features as the rays from a candle flame were allowed to fall upon his face in an

otherwise perfectly dark room. During this time it was absolutely necessary to shut out every ray and pencil of light from the sides of the curtains, and all evidence of daylight from any source, owing to her extreme *intolerance* to this form of light, the presence of which occasioned intense suffering, for it must be remembered that we were dealing with a retina that had never been used for purposes of vision, and furthermore had been shut in from the stimulus of light during her whole life, excepting that of a much *subdued* and imperfect one, hence little wonder that light proved so unendurable. On the seventh day she was allowed to look for a moment, with the same source of light as used at the inspection before, and in the same dark room, and she saw through a + 15 lens "the doctor's face with overwhelming distinctness." During the next few days light was even more distressing than before, and *white light* from the counterpane on her bed, or *white* handkerchief in her hand, caused so much distress that a dark object as a covering must be substituted for them; the eye was becoming increasingly irritated; felt as if sand was in it, and the lachrymation became acrid and excoriating to the surrounding integument. For these symptoms, combined with the fact that she was much more sensitive to *daylight* than to artificial light, Graphites was prescribed; under Graphites is found in its proving *great intolerance of light, daylight being much more trying than artificial light; great photophobia; light dazzles the eyes; great intolerance to white light, causing dazzling and lachrymation; sandy feeling in eyes; acrid lachrymation and smarting sensation, as if something acrid had gotten into the eyes; the integument surrounding the eye is excoriated by the acrid lachrymation.*

She promptly and markedly gained from the use of Graphites, and as the eye got stronger, and she became gradually able to bear the stimulus of light,—an education to which was encouraged by a gradually increasing exposure to it, beginning in the dusk of evening,—she would amuse herself in looking at the newly-forming leaves on the trees, which delighted her from its novelty as would a child be interested in a pleasing toy. For a time she was troubled by the *retention of luminous or bright objects upon the retina*, i. e., having looked at a *white* or *bright* object, its *impression* would be annoyingly retained in the eye for ten or fifteen minutes, and only gradually fading till perhaps disturbed, and renewed again by a *similar* retention from another exposure. This annoying symptom is found under Tabacum, as well as under several other remedies, but Tabacum seemed to cover more completely the general neurasthenic picture of the patient, and Tabacum rapidly dissipated the annoying discomforture, thus proving its position as the *similimum* in *this* case.

In four weeks from this time a lens of + 6 D was given for distance use, and a gradually increasing visual ability resulted; the nystagmus, which is associated with eyes that have never been able to *fix* objects

by clear seeing, gradually improved till the eyes were relatively steady, thus correspondingly increasing her power and ease in seeing.

In September following, four months after the right eye had been operated upon, the left eye was taken in hand with reference to an operation, and a similar disorganized lens body removed, as was taken from the right eye. In the posterior capsule of this lens, and extending backward into the vitreous body, was also a similar state of calcareous degeneration, with numerous lumpy, limey concretions distributed throughout its substance; hence the same method must be employed for its removal as was done with the other eye — by means of the hook. Just as the degenerated limey tissue was punctured, with reference to removal, a sudden, spasmodic contraction of the ocular muscles occurred, accompanied by severe pain in the eye; the facial muscles and those of the eyeballs twitched convulsively, and the teeth chattered, so I was obliged to *hastily* remove the instrument, and await the recovery of the composure necessary for procedure.

I want here to say that the use of ether seemed contra indicated, owing to an hydertrophied condition of the heart, although such a neurasthenic case can scarcely be as safely operated upon without it as with; simply, however, on account of the condition of the heart I feared the result of anæsthetic inhalation, so risked the cocaine instead; in two cases of congenital cataract operated upon since, one in a young man seventeen years of age, and the other in that of a girl, an inmate of the kindergarten for the blind, eleven years old, sulphuric ether was administered. After a short rest the patient became quieted, and the operation was again undertaken, but just as the posterior wall of the capsule was being torn away, renewed spasms of the face and eyes occurred, and the instrument was in consequence again hastily removed, bringing with it the disorganized capsular tissue, rolled upon its beak, accompanied by a profuse gush of fluid vitreous, bathing the hollow of the orbit and surroundings copiously. Daylight flashed into the eye as the foreign substance was removed, affecting her painfully; the previously prepared compresses were hastily applied and the eye firmly bandaged. For several days and nights she had severe stabbing pains, accompanied by a feeling as if cords were fastened to the center of the eyeball, and occasionally jerked inward and sideways toward the nose, followed by a relaxing sensation; she had *painful crashing feelings, as if something was breaking within the eyeball*, coming in remissions and exacerbations; again the *eye felt as if stretched widely open under the bandage and on attempting as if to close it the pain was greatly aggravated*; the *eye feels as if badly bruised*. On removing the bandage for the purpose of dressing the eye, a feeling of softening of the eyeball was noticed, with an accompanying sensation as it "twould drop out;" these discomfortures were largely ameliorated by loosening the bandages permanently, so that on the third day following the operation strips of gold beater's

skin were substituted for it, and the lids controlled by stretching this thin adhesive plaster across from lid to lid, thus holding the lid firmly, so as to make a uniform and gentle pad, for the *support* of the globe, and at the same time avoiding the *pressure* that came from the presence of the bandage roller.

On the sixth day she was permitted to open the eyes in the dark room, in which was only the shaded flame of the candle, nothing could be seen from the eye, excepting an objective appearance as of a dense, reddish-brown, wavy, luminous mist, moving and quivering as the eye moved, and entirely obscuring the perceptive ability. Sleepless nights followed, accompanied by much pain in eyes and head. Arnica was prescribed, owing to the existence of the *extreme bruised soreness of the eyeball, aggravated by pressure and motion*, and the fact of the condition having its origin in a *traumatic lesion* with the rough handling that accompanied it. The following symptoms became prominent however, about this time, viz.: the eye is invariably *worse during the evening and at night*, and always more comfortable in the morning. She had *intense thirst, with heated feeling of the mouth*, and a *great desire for very hot drinks*, and *she felt much better during and after drinking it*; was *aggravated while eating*, and *also on lying low in bed*, so that she must recline with the head very high; *had chilly feelings flitting up and down the back and legs*; she felt *very nervous*, was *aggravated by noise* and *had a desire to cry*, though she controlled it with much effort of the will; the eye lachrymates much, and felt at times during the night as if it painfully bounded outward, being held there for several seconds, and then relaxation followed, with corresponding relief. Her mouth was parched and herpes appeared on the lips. The nystagmus became greatly augmented. In two days after her first attempt to see, the red mist in the visual field had assumed the appearance in shape of a large half moon, nearly covering the visual area, and swaying before the eye at each attempt at visual effort; she had pain in eyes with a scratching feeling, greatly increased on lying down; the eyelid perceptibly drooped, with little ability in its control. The least ray of daylight dazzles and effects the eye painfully. Under the proving of silicea are found the following symptoms, viz. *aggravated in the evening; aggravated at night; aggravated from daylight; aggravated on lying down; aggravated from noise*; *aggravated while eating; great desire for hot drinks, and is ameliorated thereby; dense blackness passing the visual field at times; chilliness amounting to a shuddering running over the back and limbs; a feeling as if the eyes were drawn backward with strings; eyes inflamed from traumatic causes.* All these symptoms are under silicea, and consequently silicea was chosen as having a strong likeness to the probable *similimum*, hence with prospect of inducing restoration in the injured tissues, providing destruction of the retinal elements had not already occurred, through the *extensive detachment of*

the retina, that had *certainly already taken place.* For the few succeeding days she had flashes of brilliant lights, by spell, travelling rapidly across the visual area, both with the eyes open and shut; these flashes being followed by short intervals of dense blackness; sometimes little semi-circles of light would traverse the visual plane, starting from the inner angle and crossing to the outer side, succeeding each other in rapid succession; these phosphenes were more marked evenings, continuing till falling asleep. In two days after the silicea was prescribed the density of the red mist had noticeably lessened, and she reported "the first painless night since the operation, having slept till 8 A. M.;" the prickling feeling in eye is scarcely noticeable when quiet, but on attempting to move it the sensation became painfully apparent. The objective appearance of light in the visual field is still noticeable in the dark, with the eyes open or shut, and the illumination still quivers and vibrates with each motion of the eyeball. Silicea was continued. Ten days after this time, improvement was still progressing, and vision had noticeably advanced both in steadiness in fixing the eye, as well as in clearness in visual detail; objects were becoming noticeably clearer through the misty field; the half-moon shaped red mist had become broken in upon by streaks of light; the eye still smarted as if something acrid had been poured into it, the lachrymation was worse while eating and the evening aggravation was to a degree noticeable; she was sleeping better, however, but still needed her head high, supported on three pillows; *she continued to crave hot drinks and was also relieved by them.* All these symptoms are those of silicea, so silicea was continued. Notwithstanding the eye was steadily improving, the pupil was becoming gradually *misplaced upward*, through the iritic adhesion to the false membrane, that had formed in the process of inflammation till the pupil was almost concealed from view, and contracted to a mere slit in size, occupying a position so far under the upper lid as to become entirely useless for visual purposes.

The subjective symptoms of the visual field kept improving, the dark cloud decreased in density and area, gradually disseminating into fragments through the interstices of which the field of vision was clearer; as improvement still progressed the visual area became stripped off into bars of alternate dark and light lines, converging to its center, like the spokes of a wheel; the vibratory *consciousness* of the intra ocular media still improved, though the whole field of vision seemed tinged with yellow, so that everything partook of that color in appearance. As restoration advanced, the state of reddish and yellow obscurity resolved itself into an appearance and sensation to her as if the eye was full of a liquid in which were numerous black specks; the alternate bands of black and white had reduced in size and space, appearing now like three separate crossed lines, occupying an area across the visual plane, and sight was thereby correspondingly im-

proved. Saw at times little rings of white, followed by intense blackness, floating across the visual plane; with the eyes closed she had a hazy appearance, with bright blue or violet color in the field. The sense of pulling and tension in the eye continued, and was probably largely induced by the *misplaced situation of the iris*, in consequence of being drawn tightly upward, with the illy-formed pupil occupying a position well under the upper lid; this sense of tension interfered considerably with the comfortable co-ordination of the eyes, as well as with the visual ability. The sensitiveness to daylight continued, especially in the morning, on waking, so that she must gradually accommodate herself to its presence in order to be able to endure it.

Continued Silicea. Improvement in the objective appearance in the visual field still advanced till nothing remained of the flashings of light and the reddish, smoky mass in the field of vision, excepting two little brown spots, surrounded by a nebulous, steamy appearance, like thin, white, misty clouds, through which she could see objects; the hyperæmia of the sclerotic and conjunctiva had nearly disappeared.

Five months after the last operation one was made for an artificial pupil; the result was a clear, black pupil, unfortunately too large for its cosmetic effect, but with the merit of materially improving the visual acuteness, and *relieving* all the sense of drawing and tension to which she had been so long subjected. The vision in the right eye also correspondingly gained as the tension in the left iris was relaxed by the relief given to its overstretched, radiating fibres by the operations. On account of the visual ability, brought into use by the artificial pupil in the left eye, diplopia developed, more noticeable when in the recumbent position, and the comparative appearance and situation of the image received by the left eye was smaller and somewhat below the plane of that seen with the right, thus showing a right hyperphoria existing.

Astigmatism having been detected by tests, glasses were adjusted, with which vision was materially improved over that permitted by the spherical lenses first given. The difficulty in adjusting glasses in such a case is apparent, when we consider the *unsteadiness of the eyeballs* (mystagmus), and she became even less able to *fix* the gaze when feeling nervous from the *necessity* for so doing; in conjunction with this there was a large amount of involuntary and spasmodic power existing, due probably to spasms of the extrinsic muscles, making a clonic state of artificial accommodation, whereby the choice of a lens was most difficult, and very uncertain in result. The eye and general state were much *aggravated at the time of menstruation*, which covered a period of five days, during which she was lachrymose, *cried when sympathized with; had much sinking, gone-feeling at the stomach;* and at times, as she expressed it, "*the joy of seeing is almost more than I can bear, and then I am filled with gloomy forebodings that I may not always see;* at these times my eyes feel badly, and I want

to be alone." These symptoms are all found prominently under the proving of Pulsatilla, and Puls. 30 dissipated the whole train of symptoms. Sphero-cylindrical glasses, combined with prisms, were now chosen for permanent use, and they increased the visual acuity to $\frac{3}{4}$.

About three months after this choice of lenses she reported that, notwithstanding her vision was steadier and clearer, she had been gradually developing spells of blurriness, as if looking through a yellow haze, especially during the menstrual periods; these hazy spells would sometimes merge into a condition of complete blindness, or blackness before the eyes, lasting sometimes for fifteen minutes, and as the sight gradually returned, she had an appearance of threads or hairs before her, and objects looked distorted in form, becoming, however, normal in shape and appearance when the attack had fully passed. At these times she is in a condition of great general nervousness, with numbness of the feet and hands, and a sense of lassitude pervading the body, especially of the lower extremities. For these symptoms Alumina was prescribed, with wonderful benefit resulting, the whole train of symptoms rapidly disappearing, and the visual facility correspondingly advancing in usefulness, permitting reading and an ability to go about unaided and alone, a privilege she had been unable to enjoy earlier during her whole life. I wish to call particular attention to the wonderful efficacy of Silicea in this case; an influence so astounding as to overcome an evident *extensive detachment of the retina, with abundant subretinal effusion.*

This detachment of the retina was the complication that accompanied and followed the loss of vitreous humor at the time of the operation. Retinal detachment is always of serious moment, and a very unfortunate complication; after such an occurrence, vision is at best *seriously curtailed and defective if not absolutely lost*, so say and write expounders of the "regular" system of medicine. Certain it is, where without the wonderful aid permitted us in the application of remedies, according to our law of *similars*, parallel cases *must result in total and absolute blindness.* Although the use of silicea permitted the main and primary advance in the restoration to the detached retina, its usefulness was supplemented and re-enforced by the action of pulsatilla, tabacum and alumina, each remedy performing and fulfilling its special mission, according to the great law that guides in applying remedies to diseased expressions in the system.

She now enjoys most useful vision, and as the years go on her sight becomes stronger and more useful, till now, and for several years past no complaint has been made concerning them.

The case of iritis spoken of as a complication after cataract extraction, went through the usual course of a traumatic iritis, and was cured by belladonna and sulphur, the symptoms calling first for bell., afterward for sulph., which completes the cure.

The case of fistulous opening and leakage of the aqueous humor was in that of an old lady, who had had a cataract extraction some months before I saw her. This fistula into the anterior chamber was cured by *one touch* from a finely pointed pencil of caustic potash, care being taken to insert it with exactness, within the fistulous opening, and immediately thereafter applying water to offset the quickly corroding character of the agent. A prompt cure was effected, and in a few months following, I removed a mature senile cataract from her other eye without complication supervening, and good vision resulted.

The aseptic method applied in my cases is simply that of cleanliness; cleaning with soap and water, wiping off with alcohol, and finally with pure water, then drying thoroughly.

All compresses and bandages are made aseptic by great heat. The instruments are immersed in boiling hot water, and dipped in absolute alcohol, then finally rinsed in boiling water.

DISCUSSION.

In opening the discussion on Dr. Suffa's paper, "Traumatic Puncture of the Sclero-Corneal Junction," Dr. J. Miller Hinson said: In regard to this particular case, I have nothing to offer. Through the courtesy of Dr. Suffa, I had the pleasure of watching the case through its entire course, and the results fully substantiate the correctness of his judgment and treatment. As to these cases in general, each individual case must be an index of its treatment. There are a few points to be noted:

1. The character of wound and the condition of object producing puncture.
2. Is there prolapse of iris with incarceration in wound?
3. Has there been dislocation or escape of lens?
4. Has there been appreciable loss of vitreous.
5. The length of time elapsing between accident and time of seeing case.

As a general rule, I should say if you see case within twenty-four hours and find prolapse of iris, you should endeavor to reduce either by atropine or mechanical means, or both combined. If this fail, which it probably will, you should cut off prolapsed portion of iris, and free edges from wound. An eye with a portion of iris adherent to or incarcerated in a corneal scar, is a constant source of irritation and danger. In cases where there has been marked loss of vitreous, enucleation, evisceration or some modified operation is indicated.

Queries. — Isn't it good surgery to run some risk for a considerable gain? I consider it a decided gain if we can free the edge of prolapsed iris, even if we have to *reopen wound.*

2. Isn't the danger of septic infection greater if we allow the mass

of prolapsed tissue to slough away or be absorbed, than if we excise it and leave a clean, healthy wound?

Dr. A. A. Klein had had two cases of injury somewhat similar to those mentioned. One was a cut with a knife, but case not seen until the next day at the clinic. Fully one-half of the iris was cut through and a large part hanging out of the corneal wound. He cut off the projecting piece and washed the eye carefully with corrosive sublimate, reintroducing what he could of the membrane, and bringing the edges of the wound together and bandaging. The wound got along very well and there was some return of sight. The pupil was drawn to the inner side of the orbit.

Dr. Suffa said that the point of his paper was, not to meddle with the wound unless there was some good indication. If he had a large wound with a portion of the iris prolapsed it was good treatment to incise. He had had two other cases which he had treated in the manner related. In each case a blow upon the eye had torn the iris and dislocated the lens under the conjunctiva. One case was seen soon after the accident, the other, under the care of the family physician, not until a week after the injury. One had a great deal of swelling but the lens could be made out above and through to the inner side of the conjunctiva.

The text-books gave but a meagre idea of any treatment. One had said let it alone and remove the lens after the healing, if necessary. This was the advice he had followed and with satisfaction. Later on the lens became softened and was easily removed. There was some escape of the vitreous, hemorrhage prevented a view of the fundus for some time, now has a good eye.

In discussing paper by Dr. A. A. Klein, on "Complications after Cataract Operations."

Dr. John H. Payne said his experience differed from that of the speaker who stated that the loss of the vitreous was rather common in cataract extraction, and was a bad affair. In nineteen years practice he had lost considerable vitreous during operations, but had never seen any bad results, and had never had any attachment of the retina. In one case he lost considerable vitreous and had bad complications, but the case finally did well. It was in a patient on whom he had operated successfully some years before for cataract in the right eye. This time she left the hospital before healing was complete. She was very nervous and complained of pains in abdomen, and wanted to get home. Two days later she had an operation, and during this time the eye was practically overlooked, or received no special attention, until he was called a few days later. Vision was two-thirds. He believed loss of vitreous was largely due to the operator, and the making of too

small an incision. In all forms of unclear or senile cataract he believed in making a large incision, even to one-half the circle, if necessary. The lens comes out with perfect ease, escapes of itself sometimes, thus avoiding any undue pressure. He could, of course, imagine a case where the escape of the vitreous might not be the fault of the operator. A small incision requires the use of a good deal of force to express the lens, stripping off sometimes a part of the cortex while doing it, and thus leave behind an irritative focus, and inflammatory results. There is also apt to be bruising of the iris, with tearing of the edges of the wound, and even eversion. In regard to the needling operation his experience had been that if the cortex is thoroughly opened and removed there was very little necessity for a secondary operation. He thought this was due to the large incision, and by the use of the " T " incision the edges of the flaps could be more easily managed.

Dr. Knapp, than whom there was probably no more expert operator, used the small incision, and has a great deal of needling to do afterwards; he expects to have. He thought a great deal of success depended upon the after-dressing, for there was great danger of too much pressure upon the cornea. He used soft silk adhesive plaster as prepared by several concerns. It was put on in strips, and the lids allowed to act as a splint to keep the edges of the cut together. He had less astigmatism and a more regular cornea. By this dressing you left the inner canalicula free for the flow of tears, while you can watch the edges of the lids for any signs of danger throughout the whole healing process.

Dr. Hinson said he had seen one case where the transplantation of the cornea had been attempted, but without success.

Dr. Klein said that in preparing his paper he, of course, quoted from different authorities, and not from his own experience entirely. He had seen some noted operators lose vitreous, and thought it was no discredit to him if he lost some. Partial loss does not result injuriously, for the aqueous humor will replace the loss. He did not think it was due so often to the operator. He had not had any complications from the loss of vitreous, but had had other bad complications.

Dr. Payne said that Dr. Willard, of this city, experimented considerably upon the transplantation of the cornea, but without any visual success, at least. Union took place in some cases, but it left an unsightly scar.

PROCEEDINGS

OF A

SPECIAL MEETING.

WESTBORO, JANUARY 11, 1899.

A special meeting of the society was held at the Westboro Insane Hospital on Wednesday, January 11, 1899.

Upon arrival at the hospital the new building recently erected for the treatment of the acute insane, was inspected by the members, and all were much pleased with the perfect appointment of the same.

At 12 M. the meeting was called to order by Vice-President Dr. George S. Adams, and Dr. F. P. Batchelder was appointed Secretary pro tem.

Dr. Batchelder: — "One of our fellow members, Dr. Hunter of Lowell, passed away early this morning and it seems suitable that at this time we should take some action upon this event, and I move that the Society extend to the family of Dr. Hunter our sincere sympathy in this time of sorrow, and express our appreciation of the worth of the man as a member with us and as a physician. It would seem desirable though perhaps a little bit out of the ordinary routine in such a case, to appoint a committee to consist of three of the older members, who have known Dr. Hunter, to formulate this resolution and have it upon our records."

The following were accordingly appointed to constitute such committee: — Drs. J. K. Warren, E. H. Packer, G. F. Martin.

REPORT OF THE COMMITTEE ON GYNÆCOLOGY.

NATHANIEL W. EMERSON, M. D., Chairman.

I. The Gonorrhœal Infection in Women. James Krauss, M. D. Discussion opened by Winfield Smith, M. D.

II. Report of a Case of Menstrual Melancholia. Will Surgery Relieve? J. Emmons Briggs, M. D. Discussion opened by Edward P. Colby, M. D.

III. One Year's Work in Abdominal Surgery. Nathaniel W. Emerson, M. D.

THE GONORRHŒAL INFECTION IN WOMEN.

BY JAMES KRAUSS, M. D.

The subject of gonorrhœal infection in women presents the interesting example of a great truth winding its way through a mass of false teachings. Nœggerath observed among his patients what he conceived to be the ravages of gonorrhœal infection and came to the conclusion that gonorrhœa is an incurable disease; that there is a form of gonorrhœa which may be called latent gonorrhœa; that this form of gonorrhœa though latent has yet the power to infect; and that infection from latent gonorrhœa may manifest itself by an attack of acute gonorrhœa or by an attack of gleet. These conclusions have for twenty years been the cherished opinions of a large class of medical practitioners, and yet are so far removed from truth that today what is known of gonorrhœal infection is exactly the opposite of what Nœggerath taught and many physicians still believe.

Gonorrhœa is not an incurable disease. That there are uncured cases of gonorrhœa does not vitiate the fact that these cases can be cured. We maintain that there is either gonorrhœa or no gonorrhœa; there can be no such form as latent gonorrhœa wanting in both clinical symptoms and the bacteriological criterion. If latent gonorrhœa has the power to infect then we insist that this gonorrhœa is not latent, but active like any ordinary gonorrhœa; and if infection from latent gonorrhœa may manifest itself by an attack of gleet, then we maintain that that gleet is different from the gleet known to us, since in all our collective experience we have never seen gleet occur in the beginning of the infection, but always as the result of an uncured acute gonorrhœa.

There are several factors which help to make gonorrhœa the formidable disease that it is in women. Foremost stands the fact that only in rare instances does a woman realize that she is infected. The large surface of the genital passages that is open to infection moderates the symptoms of an acute gonorrhœa, so that a woman who is always more or less indifferent to genital discharges seldom suspects the mischief that is beginning to grow upon her. Only in the rarest instances is she forced to seek relief for acute symptoms. The urethritis, which is the most frequent condition following infection, is not so severe as the urethritis in man; and when it gives rise to severe symptoms, these cease abruptly, and the woman thinks that she has only taken a cold. The endocervicitis, which is the second most frequent manifestation of primary gonorrhœa in women, causes symptoms that are milder even than those of urethritis. Symptoms severe enough to seek relief are found only in young women in which the cornification of the vaginal epithelium that usually follows upon sexual indulgence has not yet taken place. Vaginitis may be extremely painful, but this is the least frequent form of primary gonorrhœa in women. More frequent than vaginitis is even vulvitis, an infection that points to a failure of copulative penetration, and vulvitis is only rarely painful.

A woman may thus be infected, and yet have no suspicion that she is infected. When a person by habit becomes indifferent to genital discharges, we can easily understand that an increase in the discharge will not make much impression. And yet, in the majority of cases, an increase in the genital discharge is the only symptom that the patient may notice upon infection.

Every genital discharge, then, should be looked upon as suspicious, and its origin and its nature should be ascertained as early as possible. The diagnosis of gonorrhœa can be made positively only upon the demonstration of the presence of gonococci in the discharge. Our suspicions of gonorrhœa may be roused by clinical findings such as urethritis, the so-called maculæ of the vestibule, condylomata acuminata, or abscess of the glands of Bartholini; but the only criterion of the presence of gonorrhœa is the demonstration in the discharge of gonococcus.

The practice of referring in a loose manner almost all ailments of women to gonorrhœal infection is to be condemned. It is the easiest thing in the world to convict a case upon the theory that the husband has at some period before marriage been infected; for, in my opinion, the statement of Ricord that 800 out of every 1000 men were at some time or other punished in the service of Venus still holds good. But a great many of these cases are cured, and a good part of those that are not fully cured have left only lesions that cannot possibly transmit gonorrhœa. I have had several cases brought to me because an abscess of one gland or both glands of Bartholini and some discharge

suggested gonorrhœal infection. From the clinical standpoint such a course appeared to be justified. But the fact is that an abscess of the glands of Bartholini may and often does result from simple traumatism incident to copulation which opens the mouth of the gland for the entrance of streptococci and staphylococci, micro-organisms which are in abundance even in the normal secretions of the vagina and are certainly found upon the prepuce and the skin of the penis. These abscesses, so often innocently present in brides that they deserve to be called "the bride's abscess," cannot be considered pathognomic of gonorrhœa. They are only suggestive. And the same applies to a discharge, the result of sexual hyperæmia. On the other hand, no discharge can be said to be innocent because it is scant in amount. A case in point is that of a patient brought to me by Dr. Johnson of Skowhegan, Maine. There was some question as to the nature of her ailment. By means of a wire speculum I unfolded, near the posterior cul-de-sac, on the vagina, a superficial but distinct erosion, from which a little muco-pus exuded. It was easy to demonstrate in the pus the presence of gonococci. It is not the history of previous infection in the husband, nor the presence of pus, nor the quantity of the pus, nor its color that decides the gonorrhœal nature of a discharge, but only the presence of the gonococcus.

Every genital discharge invites the most thorough examination. If this were done as universally as it should be done the gravity of gonorrhœal infection in women would be very much diminished. For not only would the cases of gonorrhœa be recognized, but they would be recognized at a time when they can be cured more easily and certainly than at any future period; and thus further mischief would be prevented. The danger of gonorrhœa does not consist in its supposed incurability or tendency to assume a latent character, but in the fact that gonorrhœa, when left uncured, extends into virgin tissues; that it infects the many follicles and the glands that stud the mucous membrane of the genito-urinary tract; that it invades structures that are essential for purposes of menstruation, conception and parturition; that disorders may thus be generated which, in their chronic state, maim the happiness, and in their acute state, attack even the safety of life. Urethritis is known to lead to cystitis, and this to pyelitis and pyonephritis. Vulvitis leads to Bartholmitis. Vaginitis as well as endocervicitis may go on to endometritis, to salpingitis, to pyosalpinx, to oophoritis, to perimetritis, and to parametritis.

All these are definite diseases with definite symptoms; and yet may come upon the patient without a suspicion, until she is brought down with an attack of pelvic peritonitis, from which she apparently recovers, but which recurs from time to time. When a woman gives a history of recurring attacks of pelvic peritonitis, it usually indicates a gonorrhœal tubal disease, and upon bi-manual examination we may be able to outline a gonorrhœal pyo-salpinx.

These are the two symptoms which should direct our attention to the possibility of gonorrhœal infection:

First, a genital discharge of pus or muco-pus.

Second, recurring attacks of pelvic peritonitis.

A tendency has been fostered of late to exaggerate the frequency of gonorrhœal pelvic disease in conjunction with the notion that gonorrhœa is incurable. If we remember that these pelvic diseases are all secondary to vaginal or cervical gonorrhœa, suspicion will direct us to obtain the clinical and microscopic history of a focus of primary invasion before we diagnose gonorrhœal infection; and if we remember that the gonococcus is an organism subject to biological laws, and that the biological law, that everything that lives must die, holds good for the gonococcus no less than for man, we shall admit that the time must come when the infectiousness of a disease due to gonorrhœa ceases. The morbid process of gonorrhœa is the same whether the subject is a man or a woman. It is a catarrhal and exudative process, involving the epithelial layer of the mucous membrane, which becomes eroded; an infiltration of round cells takes place in the submucous connective tissue, and the cylindrical epithelium is replaced by a layer of pavement epithelium. For constitutional reasons, the regeneration of the epithelium may not be perfect and thus erosions and ulcers are left behind, which tend to persist indefinitely, although they no longer possess an infectious character. This is a fact of every-day occurrence. Men who have had gonorrhœa years before continue to suffer from erosions of their urethral mucous membrane, and though they cohabit with their wives, these show no signs of infection. The simple reason for this is that the gonococcus is absent. A striking instance of this fact is now under my observation in the person of a physician, a colleague who is sufficiently versed in the matter to make a good witness to this statement.

That such a result can be obtained by proper treatment will not be denied. But I have time only to say just a word on treatment. Of the many medicines vaunted for the cure of gonorrhœa in women, only two have given me satisfaction in their use. The one is Aconite, the other is Sepia. For acute primary gonorrhœa, Aconite, in my opinion, is the best internal remedy; after the severity of the inflammation decreases, Sepia steps in as the most efficient drug. I do not decry the usefulness of individualization, but, on general principles, Aconite and Sepia will do more to combat the morbid process of gonorrhœal infection in women than any other two remedies that I have so far had occasion to try. But the best internal medication cannot suffice to prevent the gonococcus from invading neighboring structures, and this can be accomplished only by local treatment. Janet's irrigation, with solutions of permanganate of potash, is an excellent procedure in urethritis. An abscess of the glands of Bartholini is to be laid open and packed to the bottom. Vaginitis at

first may rebel against local application; a lukewarm antiseptic douche, however, will be tolerated; later the vaginal walls are laid bare by means of a wire speculum, dried, swabbed with cocaine, then with a strong solution of corrosive sublimate, and finally tamponed, the tampon carrying, as my preference, a 10% glycerine preparation of ichthyol. In endometritis the os is dilated, the endometrium cleared of the pus, and then painted all over with a caustic solution, my preference being for that known as Lugol's solution; when the endometritis is chronic the curette is in its place, but is to be followed by a local caustic application, like Lugol's solution. As we reach the appendages we come to major pelvic surgery, and this takes me outside the purpose of this paper. But, in closing, we may affirm that when the primary forms of gonorrhœa are given the necessary treatment, the secondary form will not appear.

REPORT OF A CASE OF MENSTRUAL MELANCHOLIA.—WILL SURGERY RELIEVE?

BY J. EMMONS BRIGGS, M. D.

It is my intention to present to the Society this afternoon the report of a case of recurrent melancholia which has been under my care more or less during two years. The case presents certain grave and important questions which it would seem might be profitably considered at this meeting where the sections of Gynæcology and Insanity and Nervous Diseases report.

It may be of advantage to state at this point, that the operation under consideration is tubo-ovariotomy, its purpose being to produce an artificial climacteric, and it is earnestly hoped that members of the society, specialists on mental and nervous diseases, gynæcologists and general practitioners, will relate their experiences and convictions in the discussion opened by this report.

Patient, Miss Q., aged 31, dark complexion and black eyes. Born in New York City. Her father was a Parisian, her mother a Canadian. Her father died of a fever when she was four years old. Her mother is now living and in excellent health. As a girl the patient was well and strong. After her father's death her mother travelled extensively, and at the age of nine the child was placed in a convent to be educated. Here she remained until after she was fourteen. While in the convent her life was most methodical and well regulated. The hours for study were short, the recreation ample, and the hour for retiring was 7.30 o'clock. When about fifteen she left the convent and lived with her widowed mother for about eighteen months.

Her weight at this time was 140 pounds, and she says she was perfectly well. Her first menstruation occurred when she was fifteen. Her periods were regular and normal for the first six months when she skipped six or seven months and then menstruated regularly again until pregnant.

At the age of sixteen her sensational career commenced. She had been out from under the instruction and care of the sisterhood a little more than a year and a half, during which time she had been living with her mother, when suddenly owing to financial reverses she was compelled to support herself. She secured a position as book-keeper in a gentlemen's furnishing store in New York city which necessitated her leaving home. Here she met a man fifteen years her senior, whom she married after a very short acquaintance. She soon became pregnant and on October 19, 1885, was delivered of a son. Her husband was always kind to her, but was a man of the world, moved in fast society, and was unfaithful to her. After she had been married two years a most sensational event occurred. One evening while in the company of her supposed husband, he was confronted by a woman who claimed to be his true wife. He at first denied the charge, but soon acknowledged his guilt. Shortly thereafter two or three other women claimed him as their lawful husband. Soon after this experience he left town very suddenly and was not seen again for some years. Miss Q describes her life with her supposed husband as very gay. She had a fine suite of rooms in a fashionable quarter of New York city, and had her servants, her only source of discomfort being the rather inconstant attention given her by her husband, whom she thought was "on the road" and spent much time out of the city. Her marriage ceremony was without doubt, a mere farce, but she says that the idea that she was not legally a wife never entered her mind until the night of the exposure as before related. The scene created at that time completely shattered her nervous system, coming as it did very closely upon the death of her boy. Soon after this event she became very despondent. She returned to her mother's home, where every thing possible for her health and happiness was provided. So great was her despondency that she attempted suicide by turning on the gas in her room. A servant smelling it went into her room and rescued her in a semi-conscious state. In the course of a year her condition improved, and she nearly regained her health.

In 1891, or five years after the separation, the symptoms which form the characteristic features of her case began to develop. During that year she began to notice a marked periodicity in her attacks of melancholia. She was cheerful and happy during the intervals between her menstrual periods, but with the approach of this epoch she became greatly distressed in mind, could neither eat nor sleep, and spent the greater part of the time in crying. The

scenes connected with the painful events of her husband's exposure were ever in her mind. She complained at these times of pain in the ovarian regions, headache and a sense of weight in the head. As her menstrual flow diminished and her periods came to an end, so would her mental symptoms recede, and with the cessation of flowing there would be an entire respite from all her depressing symptoms. Thus she drifted along without incident, save at several times she purchased chloroform on the pretext of killing a dog, but with her mind fixed upon self-destruction. She would make her plans to commit the deed, yet lacked courage to carry them into execution. Hysteria became an important factor in her case. Violent fits of laughing and crying, "bad spells," with general and localized pains, distressed her. But all this time she was her natural self until a few days before and during her menstrual period. Now and then it would take several days after the cessation of the menstrual flow before her nervous symptoms would entirely disappear.

In 1896 she consulted a physician because of violent pain in the ovarian regions, and his examination revealed a laceration of the cervix uteri. This he advised her to have repaired. Subsequently she entered a private hospital in the suburbs of Boston, and was operated upon September 15, 1896. For some reason there was imperfect union of the right half of the laceration. She felt no relief, and was again examined by a physician, who discovered this state of affairs, and advised her to enter the Massachusetts Homeopathic Hospital, where she came under my care. She complained of intense pain in the ovarian regions, and appeared to be exceedingly sensitive to examination. I made out a unilateral laceration of the cervix, but could find nothing else abnormal. She was advised to take an anæsthetic for purpose of examination, and to have any slight operation performed that in my judgment seemed indicated. She was chloroformed on November 24, 1896, and examination revealed the following facts: Both ovaries and tubes were found to be normal, the uterus normal in position, the cervix hypertrophied and containing numerous mucous cysts. The right side contained much cicatricial tissue, the result of healing by granulation. The cervical canal was narrow, although not abnormally so. The operation performed was repair of the cervical laceration, which was done by amputating enough of the cervix to remove the hypertrophied and cicatrical tissue. The internal os was dilated, and the uterine cavity explored. During her stay in the hospital she was excessively nervous and unhappy. The least noise in the ward disturbed her. She slept very little, ate little, and left the hospital in a worse mental condition than when she entered it.

Three months after she left the hospital she called on me at my office and complained of pain in both ovarian regions, especially the right, extending up her spine to the back of her head, stiffness of the

muscles of the back of the head and numbness over circumscribed areas, especially one leg, globus hystericus, and other typical hysterical manifestitations. These, it will be understood were not new symptoms, they having existed for years. At her menstrual periods, since the repair of the laceration, she had suffered from the same mental symptoms, extreme despondency, insomnia, hallucinations of sight and hearing, and suicidal tendencies.

She left Boston in the fall of 1897 and lived in a relative's family in New York city. Here, during her menstrual period she shut herself up in her room, would see no one, ate little, slept almost none at all and caused her friends great anxiety. After her periods stopped she would improve. During her three months stay in New York, she noticed for the first time a marked sexual erethism which bothered her exceedingly. This, like all her other mental phenomena passed off at the end of the period.

After she returned from New York she was seen by Dr. Colby with me in consultation. His opinion at that time was that she was a suitable case for Westboro. The patient and her mother did not concur in that opinion, and she drifted out of my care for a while. I saw nothing of her until September 17, 1898, when she called at my office for relief from a slight irritation of the bladder. I was surprised to see how bright, cheerful and happy she appeared. She was apparently perfectly well, had been riding her bicycle all summer and was enjoying perfect health. But she said her period never failed to bring upon her extreme melancholia. During the summer, while away from Boston, she was treated by an old school physician, who examined her and reported a stenosis of the cervix as a result of her operation. I examined her and found that the canal was quite narrow, yet a sound would pass readily. She informed me that for six months or more she had suffered much more pain during her flow, and immediately preceeding it, than ever before. After considerable persuasion from her, I consented to dilate the cervical canal. This I did about a month ago, at the same time removing a single hemorrhoid with the clamp and cautery. She remained in the hospital two weeks, the week preceeding and during her period. Here was presented an excellent opportunity to observe her symptoms closely. She was bright, cheerful and happy when she entered. The dilation was performed under chloroform anæsthesia on the day after her arrival. She continued for two days after the operation as well as when she entered. Then she became very melancholy, saw strange people in her room who seemed to emerge from a picture hanging upon the wall, and tormented her sorely; she heard voices and would call her nurse to give protection. She cried much and slept very little. Her mind reverted to the sensational scene of her life of eleven years ago. She was tortured by sexual desire, and longed for death which would end all her troubles. This condition gradually improved and in about six days she was happy again.

This account of my patient brings the narrative up to the present time. It now being her period of menstrual inactivity she is enjoying good health, and is in every respect greatly improved physically over her condition of a year ago. In fact she would pass for a person in ordinary health with ordinary mental development. She secures positions which she rarely holds longer than a month or two, because during her periods of depression she cannot attend to her duties and her employers can see readily that she is not herself at these times. I have never before seen a case of recurrent melancholia so closely connected with and apparently dependent upon, the menstrual functions.

She declares that if it were not for her monthly sickness she would be a perfectly well individual, and, with my observations, she has partially converted me to her opinion. She has on several occasions consulted me with regard to the operation of ovariotomy, and I have always discouraged her. I have never looked with favor upon the ablation of normal ovaries for the cure of hysteria, neurasthenia, melancholia or allied conditions, and have always been most skeptical about its even being justifiable. I have seen at least two patients suffering from neurasthenia who have had their ovaries removed for good and sufficient reasons (grave pathological conditions being present) develop symptoms of insanity; one being now an incurable case of melancholia, and the other of nymphomania.

It would be of interest and value to have the members of the Society express their opinions upon the point at issue, whether in this particular case ovariotomy should be performed, and also upon the subject in general.

ONE YEAR'S WORK IN ABDOMINAL SURGERY.

BY NATHANIEL W. EMERSON, M. D.

What follows is a review of abdominal work done between January 1, 1898, and December 31, 1898, and includes every case of operation which opened the abdominal cavity. As tabulated the cases are reported in the order in which they were operated. It is desired to call attention to two or three special points as illustrated by the year's work. More and more is the writer convinced that the best surgery upon the appendages removes only those parts which are actually diseased. In cases of pyo-salpingitis, if a portion of either ovary seems normal and the patient is a woman under thirty-two or thirty-three years of age, effort is made to conserve the healthy portion of that ovary. Again in degenerate condition of the ovaries, a resection rather than an extirpation of the ovary is undertaken if there is the least encouragement that any normal ovarian tissue is present. This statement is intended to be merely suggestive, however, as my experi-

ence is not sufficiently extended, either as to number of cases or lapse of time after operation, to draw exact definite conclusions. As I see it now, I believe these conservative cases have a less tumultuous convalescence by reason of the absence of a precipitated menopause. If only a portion of either of the ovaries is left behind, it seems to me that the resulting nervous condition is very much more satisfactory than when both ovaries are extirpated. I would not have it understood by this that too great risks are taken in leaving behind pathological tissue; rather that a studied discrimination is made with the hope of avoiding an unnecessary sacrifice of normal tissue.

In the past, where ovariotomy has been performed for tubal or ovarian disease, it is recognized that the after condition has not always been entirely satisfactory by reason of the imperfectly supported uterus which is left behind. As is well known, this has led to the advocacy by some operators of making a total hysterectomy where it is necessary to perform a double tubo-ovariotomy. This has always seemed an unnecessary mutilation to some who sincerely believe that the old surgical rule of sacrificing no unnecessary tissue is as sound today as it ever was, and I myself believe the subsequent life of the woman is more satisfactory and natural if the uterus is left behind, providing it is not pathological and providing it can be properly supported. I wish, therefore, to bring up the subject of ventro-suspension and ventro-fixation, and suggest a possible extension of the utility of both these operations. First of all I wish to clearly differentiate the difference between the two terms as used here. By a ventro-fixation is meant an actual fixation of the uterus to the abdominal wall proper, or, to be even more particular, to the recti muscles. This very proposition carries with it certain limitations, and its field of usefulness is therefore restricted. From the many cases recorded in the last few years, it is, or should be, accepted that ventro-fixation during the child bearing period should not be resorted to if there is the slightest probability of subsequent pregnancy. This, then, reverts the operation to conditions which are developed subsequent to the menopause, natural or artificial as the case may be. In my own personal experience, it is limited to cases of complete procidentia. You are all familiar with the various old-time plastic vaginal operations in these cases, and are also familiar with their very frequent failure. Vaginal hysterectomy followed by plastic vaginal work was an improvement over the vaginal work alone, but it has not been by any means the success that was expected of it, and a large per centage of failures have resulted. After observing the very small uterus which is removed in many of these cases of prolapsus, one must question the part played by the uterus in establishing such a condition, especially so when within six months of its removal we have a complete prolapse of the vagina itself. I have, therefore, during the last year, approached this problem from above

rather than from below, and have looked upon the atrophied and practically functionless uterus as a means of suspending all the relaxed tissues involved in a condition of complete procidentia. A small opening having been made above the pubes, the fundus of the uterus is brought up between the recti muscles and there firmly secured directly to the muscles themselves. The peritoneum is turned around the body of the uterus, and the whole wound is closed so as to obtain union by first intention. After complete closure, the parts are arranged as if the fundus of the uterus had been forcibly thrust up between the recti muscles perforating the peritoneum. This constitutes a true ventro-fixation. To one who has not seen the result of this manipulation, I am sure it will be a surprise. Instead of a wide and prolapsing vagina of very shallow depth, we find it narrowed and elongated and the lax prolapsing tissues seem to have largely disappeared. If now, following the abdominal operation and at the same sitting is undertaken whatever plastic work upon the vagina seems indicated, the mechanical results must be more satisfactory than by any other method heretofore advised for this annoying condition. What the ultimate result will be in any given case I cannot say, since sufficient time has not elapsed for me to have determined this question from my own operations. The immediate result has certainly been more satisfactory than that obtained by any other method I have heretofore employed, and no relapses have as yet reported. The only objection to this operation, which former experience has suggested, is that a loop of intestine may pass between the uterus and the bladder or abdominal wall and become strangulated, and to obviate the possibility of this, a variation upon the present method in both ventro-fixation and ventro-suspension will be suggested and discussed later on.

Ventro-suspension is applicable to a very much more extensive class of cases and variety of conditions, many of which are post-operative. In cases of backward displacement, where Alexander's operation has failed or is not indicated, to my mind it offers the best solution to a very difficult problem. If properly done, it is safe in young women who afterwards become pregnant, and I myself have had one case where pregnancy following the operation caused absolutely no discomfort, and delivery was normal. The operation, moreover, permanently relieved the displacement. For displacement, the abdomen is opened in the middle line and the fundus brought up to the abdominal opening. Two silkworm stitches are then passed through the anterior portion of the fundus and upper part of the anterior wall of the uterus in such a way that they are firmly buried in the uterus for about three quarters of an inch, and are about three quarters of an inch apart. The sutures are next passed directly through the abdominal wall upon their respective sides and about one inch from each other, and then firmly tied on either side upon

pads of gauze. The fundus of the uterus where it is in contact with the peritoneum is previously sacrificed, after which the peritoneum is entirely closed with a very fine catgut suture, so that it lies between the fundus and the muscles. The incision is then closed in the usual way. These silkworm sutures are removed in from twelve to eighteen days, by which time firm union between the peritoneal surfaces in apposition has taken place. The final result of this is that the uterus is suspended not immediately behind the abdominal wall, but at a varying distance from it by a cordlike elongation of the peritoneum, and this has relieved the displacement and all the accompanying ill conditions. A marked disadvantage in this condition, however, has been the fact that occasionally a loop of intestine has slipped between the uterus and the abdominal wall and become strangulated, of course causing a very serious state of affairs. To obviate the possibility of this accident, it occurred to me that a union between the peritoneum on the anterior surface of the uterus and the adjacent fundus of the bladder and anterior abdominal wall would obviate the possibility of the occurrence of this difficulty. This has been done in a number of cases with only beneficial results so far as observed. The peritoneum over the lower portion of the abdominal wall and the bladder is very lax and adaptive. After the uterus is suspended with a fine catgut a line of suturing is applied, beginning at the lowest point in the sulcus created in front of the uterus and carried directly up in the middle line, uniting the lax peritoneum over the bladder to the more fixed peritoneum on the anterior surface of the uterus, until the point of suspension at the fundus is reached. This causes absolutely no discomfort to the patient. The result is the formation of practically a third and anterior broad ligament which serves the function as well as a suspensory ligament. It maintains the uterus in support in an almost perfectly natural position, and the strain of suspension is extensively and equally distributed. It also prevents the possibility of strangulation of the bowels, and as actually practised no objection to the employment of this method has been developed. While it is here spoken of in connection with a retroverted uterus I fancy its most extended application will be found, provided it stands the test of experience, in cases of double salpingectomy or double tubo-ovariotomy where a practically normal uterus is left behind. I have used it in a number of these cases with most gratifying results so far, but again must call attention to the fact that sufficient time has not elapsed to draw definite conclusions as to permanent results. The application of this same modification to cases of ventro-fixation for procidentia makes them absolutely safe from the possibility of future accident.

This report is made on 134 abdominal sections performed on 133 patients between January 1, 1898, and December 31, 1898.

DISCUSSION.

Concerning the first paper, "The Gonorrhœal Infection of Women" by James Krauss, M. D., Dr. Powers said: — Mr. Chairman, ladies and gentlemen: — The topic is one of a good deal of interest and importance to all practising physicians and in the main I have very little criticism to make of the paper. There are a few remarks, however, to which I would raise a little objection, not with the idea of speaking any criticism, however. One of these points was that if gonorrhœa was properly treated we would have no secondary symptoms or lesions. Now it seems to me that Dr. Krauss has gotten away ahead, or that conditions are better with him than they are with the majority or even with hardly any of the physicians, in treatment. I will gladly believe that if properly treated there will be very few secondary conditions, but when you take into consideration the condition of your patient and possibly the diseased condition before infection, it seems the statement is too broad and that no physician should be held to blame because there are secondary symptoms in the case. It is possible that I am wrong on this point, but it seems to me from my standpoint I am correct. The question in regard to a latent gonorrhœa seems to me might be misleading. I admit the literal following of his paper is correct, but there are numbers of occasions where so far as you are able to elicit any symptoms the patient is apparently perfectly well, having no discharge whatever, yet there is a foci in the vagina or possibly in the Fallopian tubes which has probably not gone on long, and yet there are gonococci still present, only they are not causing a great amount of disturbance, and it seems to me the term of latent gonorrhœa is well applied to those cases. Certainly there is a multitude of cases where it has gone on for a considerable time to say the least, after infection, before secondary symptoms appear. A case in mind where during the summer months I treated the husband for urethritis. He was a married man and above suspicion, still I thought it to be gonorrhœa, but he gave an account at that time of his wife having acute vaginitis. The following winter I treated his wife for an attack of pelvic peritonitis; she had a temperature of 100° to 104°, was in bed for weeks, but later has been a complete recovery but has remained sterile ever since time of the attack. All these things make me believe that it was gonorrhœa, though she knew nothing of infection. I think the pendulum may have swung too far in considering all cases of pelvic disease in newly married women as due to the man before marriage. But I think that a great majority are due to gonorrhœal infection in the male before marriage. It seems to me that there is foundation in the inference, that gonorrhœa very frequently does persist without any material symptoms, but these symptoms are not capable of ocular

demonstration. I think it is almost impossible to diagnose only from the presence of gonococci.

Dr. Boothby: — "I only feel obliged to take exception to the statement that was made that eight out of every ten men has had gonorrhœa. I think it is a statement that is so absolutely out of place with us that it should be corrected. Statistics given do not apply to the United States, that is to the United States a few days ago. I do not know what the United States is today. Now we certainly cannot put ourselves into any such class as that and there is no sort of reasoning to suspect that eight out of every ten men have gonorrhœa at some time. I am very much inclined to agree with Dr. Powers' more conservative way of putting this matter."

Dr. Earle : — "I understood you to say that a woman who escapes gonorrhœa, her husband having urethral discharge, proves the husband did not have gonorrhœa. I do not believe that any woman may not receive gonorrhœa from intercourse with a man that has gonorrhœa."

Dr. Elliot : — "There is one practical point to which I would like to make reference. Suppose you have a young man whom you have treated for severe urethritis. According to the clinical symptoms he is cured. He comes and asks if he can be married. A rather disagreeable experience in that connection some years ago has made me adopt this as my method; that is in every case have the urethra examined by speculum and submit the secretion to the examination of the pathologist. The mere cessation of the discharge by no means carries an assurance that he is safe to marry."

Dr. Worcester : — "I think the method formerly used of having the man make water the very first thing in the morning so that the washings of the posterior urethra would be there, there would be very little question about it. Like all other forms of vegetable and animal life, gonococci die, we all agree to that, but he forgot to state that there is a tremendous reproduction going on all the time, and in that way go on and live for generation after generation. My own experience in connection with treatment of gonorrhœa in women has not been large, but I have found usually in those cases by using corrossive sublimate, one part to 500 and then washing out with hot water douches, and after that one to 1,000 and gradually diminishing the amount, after a few days the condition subsides."

Dr. Elliot : — "I have found in cases of young men who use stimulants and when the attack is apparently cured, if after that they use beer again the discharge will reappear."

Dr. Krauss : — " It is easier to answer one man than ten, but I will try to answer them all. Dr. Powers' statements run in the same channel that my statement presents. He then says later gonorrhœa may exist because symptoms may be quiescent although there may be foci of infection in the tubes. In this condition there are always symptoms present. Then I also deny that later gonorrhœa can exist for the reason that all gonorrhœa presents symptoms. Then he says that he had a case of gonorrhœal peritonitis following diagnosis. I must take exception to this because it is an effect that gonorrhœa never causes. Then he says that the majority of cases of gonorrhœa in women are due to previous infection of the husband. But when the husband has had infection then he gives gonorrhœa to his wife. He says it is impossible to diagnose only from the gonoccocci, but if it is impossible to diagnose from gonoccocci then it is twice as impossible to diagnose from clinical manifestations. Of course I appreciate Dr. Boothby's sentiments that there is not such a number as 800 among every 1,000 men, but I prefer the statement of those who keep statistics and I believe that those of the United States will present such a number because next to France it is the most infected country in the world. Dr. Earle made a good point. I believe cases may escape infection. A man may escape but a woman never. It is a fact among prostitutes that they will sometimes infect the first partner but not the second and third because these glands empty themselves. As to a clean bill of health, it should only be given after repeated examinations have proved that there is no gonorrhœa present, but I do not mean an examination of the ordinary kind; I mean that the parts must be thoroughly examined with a urethrescope or other forms of speculi and where there are erosions they must be irrigated several times, and after this if no gonoccocci have been obtained then I consider the erosions as no longer infected. With Dr. Elliot I believe that the cessation of the discharge is no criterion of a cure. I believe with Dr. Worcester, gonoccoci do die but reproduce themselves very rapidly; but we have the testimony of a single observer who has examined 1,046 cases of gonorrhœa (Gull of Switzerland) and out of these he found that after two months time there were only 20% that presented gonoccocci ; that after three years not one gonoccocci could be discovered.

Discussion on Dr. Briggs' paper, opened by Dr. Packard in absence of Dr. Colby.

Dr. Packard : — " Mr. Chairman, I am utterly unprepared to discuss this paper, still I have some thoughts on the subject. In the first place we can look back a little to what has been done in the past in the way of tubo-ovariotomy and we know that the practice ran riot of performing it, of removing healthy ovaries in a great many patients, well, because the patient felt badly, etc., for every conceivable reason.

This fell into disrepute because the patient was not cured of the condition for which the operation was performed. So that a revulsion has come about and in the last few years a great many less tubo-ovariotomies have been made than heretofore, and it may be that now we are coming down to sifting out the cases and know better how to select the cases for these operations.

Usually the pendulum swings one way and then the other until we finally strike the right balance. It has never appealed to me that it is a good operation to do unless there are pathological conditions which indicate it. There have been a few cases that have come into my hands where it was difficult to decide, and I have felt that I could not decide upon it and have referred to a neurologist, and if he expressed a positive conviction that the establishment of an artificial climacteric offered good hopes for alleviation of general nervous symptoms, why then I have performed the operation and in most of those cases where I have taken that precaution there has been after a lapse of time a good result. I have known of many cases where it has seemed to me the operation has been followed by far from satisfactory results. I should like to know just when this operation is justifiable and when it is not. There comes to me at the present time a case where operation is solicited and there is nothing about the case to call for it, in my opinion; there is no pathological condition except a slight erosion. It is an unmarried woman who is approaching the climacteric; she has exaggerated sexual manifestations but none that are not controlled, but there is a general state of neurasthenia which has existed for years. She has fallen into the hands of a physician who has talked to her of her uterus, her ovaries, etc., until she believes they are the cause of her condition. I believe harm is often done by suggesting ovarian disease. The mere suggestion gives them uncomfortable sensations there. Here in the hospital we have had very good results as following tubo-ovarian hysterectomy. There are cases undoubtedly where it does good ; there is no question but what the establishment of the climacteric causes a smoothing down of the intensity of some of these nervous phenomena. See what is done in the horse family; and what is more patient and willing than the ox, but what is he without castration? And so with the female in the human family. There is naturally in the female a less violent disposition, but we occasionally meet with over-intensity which results in sexual perversion, and I think in these cases it will do a great deal for the patient and make her a useful member of society."

Dr. Boothby: — "I do not believe in removal of the ovaries unless they are diseased. It is not always possible to detect disease by touch, and it is quite possible removal of the ovaries would result in recovery. But if you have a disease in the ovaries or in the tubes then the operation may be performed. I am convinced from cases

under my own observation that it is nearly impossible sometimes to detect disease. But it seems to me that in this particular case that so far as we know I should advise an operation for relief and yet I would not assure her the disease was not in the ovary."

Dr. Paine: — "I should also by all means expect he would remove the uterus as well as the ovaries and tubes."

Dr. Boothby : — "I agree with that last statement of Dr. Paine."

Dr Adams: — "I think it probable from my experience that the operation suggested would prove beneficial in Dr. Briggs' case. I think it however possible that mental suggestion might help. If the shock of learning her husband's unfaithfulness occurred during the menstrual period, causing the intense depression and mental suffering reported, the recurrence of the menstrual period with its pain and discomfort, would tend to bring about the recurrence of the depression in a case so evidently marked with some of the symptoms of hysteria. If mental suggestion with or without hypnotism has not been tried, it is worth being considered."

Dr. Briggs : — "One question to this effect. Is it possible or rather is it probable at all that the removal of the ovaries and more would be followed by a condition of more profound melancholia, or in other words, the patient drift into chronic melancholia when now she has periods of health?

Dr. Paine: — "As far as my opinion goes she is almost in a hopeless condition, where her life is apparently a misery, the long duration and her repeated efforts to be cured, I think the probabilities are not at all in favor of her going into melancholia, and the operation might relieve her of it."

Dr. Boothby : — "I do not believe melancholia would come about from the operation."

REPORT OF COMMITTEE ON INSANITY AND NERVOUS DISEASES.

J. FRANCIS BOTHFELD, M. D., *Chairman.*

I. The Responsibility of Epileptics: Ellen L. Keith, M. D.
II. A Case of Paranoia, D. E. Brownell, M. D.
III A Phenomenon observed in the Blood of Morphinomaniacs, S. C. Fuller, M. D.

THE RESPONSIBILITY OF EPILEPTICS: A CASE.

BY ELLEN L. KEITH, M. D.

To the physician in a state institution, epilepsy presents quite a different phase from what it does in private practice, or even in a private hospital. When epileptics are admitted to the State Insane Hospitals, they have usually become somewhat demented or are maniacal, and in most, if not all cases, are unable to support themselves by reason of their disease, or have no means by which care at home can be provided for them. Those few who are not really insane form a class to be specially considered, for they seldom realize their inability to support themselves, believing that favorable surroundings only are required for them. They chafe at being obliged to mingle with insane patients and at the restraints thought necessary for their own safety.

For the greater number of epileptics, however, in these institutions, the question of physical care only has to be considered. They must be so grouped as to insure constant supervision day and night, kept as much as possible from contact with sensitive and intelligent patients, and fed with such food as is suitable for them.

In all these cases the question of responsibility seldom enters. They are held and cared for as irresponsible.

In the outside world it is different. Social and business problems arise. The question of the right to control one's property or to undertake important business schemes, to go freely into society, taking the risk of shocking friends or strangers by sudden attacks in the house or on the street, or the right to enter the marriage relationship; these and kindred questions demand consideration.

The question, however, usually arises among the friends and relatives of the epileptic, rather than from the patient, who seldom realizes the need of any different rules from those applicable to the world in general.

It is hardly possible to conceive a more trying affliction, for it brings so many limitations to the patient, so much concern to the friends, and often very great fright or annoyance to strangers.

Perhaps we might say that the more infrequent and irregular the attacks, the more difficult it is to plan for the patient. For example, shall a young person, bright, intelligent, strong and active, capable of doing good work in many directions, or of enjoying music, art, religious and social gatherings, be prohibited these entirely because at some time an attack may occur and some of the audience may be alarmed? Or, shall such a person, a young lady, be freely introduced into society by a friend in another city, and permitted to interest the affections of a young man to the point of a proposal of marriage before he is made aware of her condition? I understand this has been done more than once.

Shall marriage be consummated if the attachment has been formed while both parties are ignorant of the nature of certain ill turns to which the lady is subject, and which prove to be epileptic?

The uncertain prognosis and the probable hereditary results make the outlook unfavorable.

It has not been my wish or intention to receive epileptics into my private hospital, yet three have found their way there in two years, and others have been refused.

I took the first, knowing the case well, and realizing the undesirability of it, but was induced to do so by the request of the family's physician, who was anxious to find a place for the young lady during the summer vacation that the family might have a little rest. She is a fair type of the young, bright girl, who, by reason of occasional attacks, must forfeit much that makes life pleasant to herself, or be a trial to others. It is hard to say she must be cut off from everything, yet duty to others has to be considered as well as her pleasure.

My second case had not been diagnosed as epileptic, though the attacks had occurred once in four or five weeks for nearly two years. It is undoubtedly a case of senile epilepsy.

My third case, and the one that by reason of some rather rare, though not unrecorded symptoms, made it seem of interest to bring before you to-day, had also not been diagnosed as epileptic. In fact the diagnosis is still under consideration.

The patient came to me through a mutual friend, who said that she was weak physically and nervously, very sensitive to all unpleasant associations, and subject to fainting attacks, which lasted hours and even two days occasionally.

Arrangements were made for me to send a nurse to Boston to meet

her on the arrival of a certain boat and accompany her to my hospital. This was done. The nurse found her very weak and tremulous, but apparently conscious and able to plan for herself. She wrote and sent a telegram from the station to her friend, and took a little breakfast while waiting for the train. I met her at the station, and took her directly to her room, where I talked with her nearly half an hour, making notes before her. She then went to bed for rest treatment, which she very evidently needed.

Nothing of interest developed during the day. She took almost no nourishment, and that only liquid, was very weak, and hands moved constantly when she was talking. Just at dusk I went to her room, and found her in what I considered an epileptic seizure. She was apparently unconscious, and was convulsed, especially in the upper extremities. Her hands clutched at her throat as if they would tear the skin with the rapid flexion and extension of the fingers. I lighted a lamp as quickly as possible, and watched with much interest this first "fainting attack." After perhaps three minutes she recovered her consciousness, or seemed to do so; said she ought not to have been left in the dark, that the dark always frightened her, and then again became badly convulsed. A nurse told me later that she had asked not to have the lamp lighted.

This was a Thursday evening. A nurse was put with her, who was up with her most of the night, though she had only one series of convulsions after I left her.

Friday she talked quietly and rationally through the day, but took no food. That night had three attacks before 11.30, and then slept. Saturday took some food and seemed better, but during that night had many attacks between 9.30 and 12. Sunday night had one, which was the last during the four weeks she remained under my care.

The peculiarity of this case now began to show itself. On Tuesday the friend to whom the telegram had been sent, referred to it, and she had no knowledge that she had sent it. More questioning brought out the statement that she had no remembrance of any events from the time she took the boat on Wednesday up to Monday. Did not recall my meeting her at the train, or of my talk with her in regard to herself.

The history she had given me at that time was clear, and somewhat as follows: Shocks had caused her to faint from a child; attacks sometimes lasted two days; mother and sister also had attacks; mother had been dead some years, but she remembered seeing her in attacks, when she clenched her hands and was convulsed, also groaned and frothed at the mouth. Patient said she herself slept poorly, and often wakened in a cold perspiration and with a sense of sinking; is conscious of a loss of consciousness at times, but can hold it off by will power for awhile, though she has no recollection of what happens during that time. The first attack that she remembers was when she

was fourteen or fifteen years old, but has been told by others that she always had them. Frequently has pain starting from the ovarian region, extending to the top of the head, and then to the heart; this is followed by unconsciousness. For some years has had a painful spot on top of her head, as if it was on fire; never dares to touch it for fear of the agonizing pain it causes.

After a week of rest in bed, patient began to go out, and soon showed rapid and marked gain in strength. It then seemed advisable to acquaint her with what appeared to me to be the real nature of her "fainting turns." At first she accepted the diagnosis, but very soon made every effort to prove that it was not correct. She utterly denied all of the statement she made when she first came; said she was so weak and exhausted then that she did not know what she said. She wrote to her sister to confirm her statement, and the sister sent me a very vehement letter, protesting that there was no such thing as epilepsy or insanity in their family, acknowledging, however, that both she and her mother had occasionally fainted, as almost any woman did, from overwork.

Patient had by this time recalled all the events of the early days of her stay; could give the exact wording of the telegram she had sent; told just what kind of paper I had used in making my notes, and showed clearly that the memory had simply been dormant during the attacks.

The failure to find any local cause for the ovarian pain seemed to cure the pain, while firm but gentle pressure of my hand one day on the top of her head, though it brought tears like rain at the time, entirely relieved her of the idea that there was a tender spot there. The sensation has never returned.

This patient had a strong motive for wishing to have my diagnosis of her case changed. She desired to marry, and she had every reason to believe that the man who was interested in her would not marry an epileptic. She is young, attractive, very affectionate; has not had an altogether happy home, and craves one intensely.

She has been considered, so far as I can learn, as perfectly truthful, honest and upright in every way. The last week she was with me she was constantly making contradictory statements, the last of which was that she had purposely made herself out worse than she was when she came, for fear I would not receive her unless she was really ill, and that she never had had the period of not remembering, had only made believe, etc., etc. In short, she was anxious to admit any amount of deception rather than be called an epileptic.

She left me an entirely changed person, so far as strength and looks are concerned, easily walking four or five miles. She left with the intention of proving by hard work that she was not an epileptic. For nearly four months she has remained well, better than for years, and is working steadily.

My diagnosis may be incorrect, but I chanced to have with me at the time of her attacks three nurses who had all had more or less experience with epileptics at Westborough, and not one of them thought of questioning the nature of the case.

Allowing that it is a case of epilepsy, is the patient responsible for her conflicting statements, or which of them can be believed?

When can such a person be considered in a normal mental condition?

A CASE OF PARANOIA.

BY D. E. BROWNELL., M. D.

Paranoia is a type of insanity ordinarily hereditary, though exceptionally acquired. The cause may be the inheritance of a constitutional psycopathetic state which may not be the direct result of insanity in the parentage, but of allied neurosis, syphilis, alcoholism or phthisis. In the cases of direct neuropathic heritage the first symptoms of singularity of thought can often be traced back to childhood, and almost invariably back to puberty.

"A considerable portion of cases arises among the hereditarily weak-minded class. Though this intellectual deficiency does not reach the grade of imbecility, it facilitates the comprehension of those cases of youthful primary monomania which in a few years pass into a fatuous state."—[Kellogg.

The case I am to report was unable to tell anything of her family outside her parents, brothers and sisters. Her parents were slaves and for many years her mother had what patient termed a broken vein on her leg. Her mother finally died of pneumonia. One half sister died of cancer. Other than this no family history could be obtained. The patient, N. T., was admitted to this hospital Oct. 9, 1898, female, colored, age 25. Her commitment papers gave the duration of insanity as one year, but on questioning patient it was found more likely to have been three years and one of those cases which really exhibited peculiarties in childhood. Her bodily health was excellent. She had been a hard working woman all her life, either going out or taking in laundry work at home.

She was very religious, could read and write and quote Scripture freely. She related incidents graphically and gave to them a peculiar dreamy coloring which held her listeners' closest attention. She said that she came north from Virginia eight years ago and shortly after went to live with her half-sister who was in poor health and who died two years later. She said that this sister exacted a promise from her that she should remain with her and care for her while she lived

and at the same time take her place with her husband. Patient stated that she had never been married but that she remained and took the name of her sister's husband and that four children had been born to them. She stated that she broke her promise soon after and in her own words told the following story: — "Once six years ago the Lord tried my faith. I got in love with a man by the name of C. W. I had promised my sister to stand for her and look after her husband but I broke my word and went to Niagara Falls to meet this man. I went, and I heard then that he was married, but I did not believe in hearsays and I staid three months. He came to me once and told me he was married and wanted me to run away with him. Then I made up my mind to leave him and return home and I told him so. He got a revolver and at seven o'clock in the morning came to the house where I was stopping. The Lord had told me that he would come and I had told the people not to let him enter the house but they did. The Spirit spoke to me that morning and said, 'Get up Nancy, it is better to be shot standing than lying.' I went into the room where he was and he says, 'Are you going home?' I say 'yes.' He then shot me in the side." Patient showed us the scars; one under the right breast where the bullet entered and one on the left side where it had passed out. She said, "The Lord told me I must go through this for not fulfilling my promise to my sister. So I went back and stood again for my sister." Her manner of living and the fact that she had broken her promise caused her to become worried and depressed. Her depression took a religious form as did the delusion which followed. In her conversation with me a few weeks ago she said: "I have seen from the beginning of the world. I have been led by the Spirit ever since I was a child. Three years ago I was led to inquire the reason why I was thus favored of God." She said further that one year ago last October the Lord first came to her, that she had been grieving for years over her trouble and had prayed and prayed without obtaining comfort. The Lord came and spoke to her in order to cheer her broken spirit and offered her relief if she would sacrifice her daughter Maud.

Last January she thought the Lord appeared again to her. She said: "I had been ironing, and was sitting by the ironing board resting, when I heard a voice call 'Nancy.' I thought someone was behind me, but there was no one there. In a few moments the voice came again, 'Nancy.' I looked upstairs, as the voice seemed to come from the ceiling, but there was no one there. Then the voice called a third time, 'Nancy,' and I knew it was the Lord. I answered Him, and He told me He saw my spirit was broken, and asked me what would I give to have it mended. I said, 'Lord, you have my heart.' He said, 'Will you give me your baby?' I loved the Lord, and I loved my baby, and I say, 'No, no;' but the Lord saw it did not come from my heart. He said, 'In the trying of Abraham I saved

Isaac.' So the Lord had only been trying my faith, and he did not take my baby then."

On entering the hospital last October she was greatly excited; said she was called to preach of God to the whole world, and the day before she had paraded the streets of Marlboro with a plank on her shoulder, which she said was a cross, and created considerable disturbance shouting messages from the Lord. For the first four days after admission she was noisy and destructive, and resented being kept in a locked ward. After that time she was quiet, but expressed her delusions freely. One day she wrote a letter to the chief of police in Baltimore, begging him to come here at once and arrest a man who several years ago had murdered a white school teacher in the South. She said the Lord had revealed to her that a certain man in the laundry was the one who had committed this murder.

Hallucinations of sight were clearly demonstrated in this case in the following statements. She said: "At times I have seen a crowd in the house, and the Lord told me they were angels. No one could see them but me. I have seen the big angel who follows me all the time, the Lord told me it was a guardian angel. It is a woman; she has long hair and big white wings. She wears a robe, white like a snow bank. In the police station where they took me before I came here, I saw a dragon, and the Lord told me it was the devil."

We have demonstrated in the case hallucinations of hearing, very probably beginning at an early age, hallucinations of sight following, and illusions through which the patient occasionally mistook the identity of those about her. Taking into consideration the character of the delusions and the activity of the hallucinations, it can be readily seen that such a case might become dangerous when outside an institution. This patient, however, was permitted to go to Virginia December 24, with her children and their father, the order for her discharge coming from the State Board of Insanity.

I have said nothing of treatment in relating the above case, because so far no line of treatment has been found curative in cases presenting fixed and systematized delusions of long duration. The case was discharged unimproved. Much could be done, we believe, in the very early stages of paranoia, before the hallucinations become fixed delusions; but at this period the cases rarely come to the physician. The treatment indicated in the beginning would be rest, change of scene, hydro-therapy and counter suggestion. The homeopathic remedies best covering the individual symptoms should be chosen and given assiduously. An analysis of the blood, and, if necessary, the administration of iron should not be overlooked. In fact, the standard of perfect physical health should be sought for, and attained if possible.

A PHENOMENON OBSERVED IN THE BLOOD OF MORPHINOMANIACS.

BY S. C. FULLER, M. D.

Some remarks on this phenomenon were made to this Society at one of its meetings not long ago, and a preliminary note has already appeared in the annual report of the Westborough Insane Hospital for the year ending September 30, 1898. Nothing new has since been added to our knowledge of the subject. The present object is to give a more detailed account of our observations, and the experiments made in connection with the study of this very interesting phenomenon. In short, to justify if I can, the position that has been taken with reference to its origin.

A pathological picture must like a photograph take in every detail of the abnormality to be portrayed; and is only fully understood when every step in its development from its incipiency can be traced and studied. With the subjects which the most of us have to deal, this is not always possible. We have frequently to draw inferences based upon the data of our accumulated experiences; and when these inferences can at least be partially substantiated by experimental evidences, we may form an opinion however qualified it may be. All of the clinical symptoms of the cases about to be discussed were given due consideration; but it is to be a particular clinical observation that I wish to especially call your attention. Before doing so, however, it might be well to refer to what led to the accidental discovery of what so far has proven an interesting incident in the study of, and apparently peculiar to cases of morphinism. It is the custom in the hospital here, with the other examinations made of patients on admission to make one also of the blood. This is done because of the almost general association of a more or less marked degree of anæmia with all forms of mental disease. If there be associated Leukæmia, Hodgkin's disease, Malaria, quite often they may be detected. If a peculiar rise and fall of temperature suggests typhoid fever, this condition may be quite safely diagnosed or excluded by the count of the leucocytes. Further certain peculiar neuroses have certain peculiar manifestations that are at times suggested by the differential count of the leucocytes. To make the examinations of value uniform methods are followed throughout. So that, if, for instance, objection be made to the Fleischl's hæmometer that it is liable to error of 1–2° in its readings of hæmoglobin percentages when the results of several hundred separate examinations are studied, its comparative value is not impaired. For counting the red cells Gower's solution is invariably used as a diluting fluid, and for the

leucocytes 1–3% acetic acid in aqua dest. The cover slips are stained with Erlich tripple, and Griffith's Eosin-Methyl-Blue stains.

It is certainly worthy of note that in more than 300 examinations where these uniform methods were used, five cases only, all of which were morphine users, showed on microscopical examination where the blood had been diluted with Gower's sol. small crystals closely resembling the smaller crystals of morphia sulph. These crystals were colorless, some needle-like in shape, others tapering to a point at one end, the other end having a broken-off or jagged appearance and with this variety there seemed a tendency to arrange themselves in stellate groups. This, of course, was never observed as there was at no time a sufficient number to accomplish that purpose. Still another variety was of a long narrow parallelogram shape. The crystals ranged in size from about 30 M to 60 M in length, and from about 3 M to 6 M in width. They were first observed in a specimen diluted 200 times with Gower's solution. Thinking that perhaps these crystals were due to fault in the technique or perhaps to a deteriorated diluting fluid, a fresh solution was made up and another specimen of blood taken and the examination conducted with great care, when they were again observed. Blood was then taken from three different sources of individuals who were not morphine users and examined with the two different fluids, and I could not demonstrate the crystals. Fortunately there happened to be in the hospital at the same time another morphine patient who had been taking the same amount as the first patient, 25 grs. per diem, and admitted on the same day. An examination was made of the blood of patient No. 2 and I without any difficulty demonstrated crystals like those already described. The general condition of the blood in both these cases was markedly anæmic, great reduction of hæmoglobin percentages and red cells. Indeed in all the cases of the opium habit that I have examined there has been marked anæmia. In one case the hæmoglobin as estimated by the Fleischl apparatus was below 20, and the red count less 2,000,000 per cubic M. There have been nine cases in all which were addicted to taking opium in some form that have come under my observation. Five of these may be considered habitues in the strictest sense, and it is singular that these five were morphine users, two of which were taking 25 grs. per diem, one 6 grs. per diem, one 8 grs. per diem and one 90 grs. with 30 grs. cocaine additional. The two which were taking 25 grs. per diem showed the greatest number of crystals. In fact in one of these cases where the drug was immediately cut off, they could be demonstrated though fewer in number, two weeks after. In the other the drug was gradually diminished but I could not demonstrate them when the patient was taking less than 3 grs. per diem. In the one taking 90 grs. I found only one crystal quite a large one but typical. This was observed on first examination about twelve hours after admission. I

should think from the greater numbers observed in the cases taking 25 grs. over those taking 6 grs. and 8 grs. per diem, that the cocaine was perhaps responsible for the small number appearing in the 90 grs. case. Just in what way the cocaine influenced the number I am not prepared to say. The other cases, four in number, were not habitues in the strictest sense, at least not at the time of admission. One according to statement was accustomed for a few months before admission to taking 15 to 20 grs. Chloral alternate nights, paregoric quite frequently, and at intervals of a week or more morph. sulph. Of this latter, however, never more than ¼ gr. at a time. According to commitment paper had for several years taken drugs to produce sleep, as the patient was evidently of a neurotic temperament and according to this statement the drugs taken were antikamnia, chloral and morphine.

Another had been using opium in some form for three years. Began by smoking it and kept it up for six months. Then started taking it in pill form 1-8 gr. morph. twice a day and increased to one gr. Then began taking it in powder form not measuring but what was thought sufficient. From October '97 to June '98 took laudanum ¼ ounce twice a day, gradually increased to one ounce per diem. The patient at this time, as claimed to produce a sensation, took two ounces of laudanum and went out for a walk, was picked up in an unconscious state and taken to the City Hospital, Boston. In two days was discharged and on the evening of discharge took ½ ounce of laudanum and ten cocktails, and being intoxicated and under the influence of laudanum was again sent to the City Hospital, remained three days and was sent home where she continued to take her customary dose, 1 ounce a day. She remained at home a week. Was then taken to the New England Hospital where she remained a week and a half without receiving the drug. Was then sent to the hospital here and the next day after admission I made an examination which was twelve days after the patient had been off the drug. No crystals were observed. The patient was anæmic, but not to so great an extent as the other cases.

Another patient was brought here from another hospital in a very weakened mental and physical condition. She had previously been taking morphine, for how long and in what quantity she does not know, as she has no memory for recent events. There were no crystals found, but a very high grade of anæmia in the examination made a day after admission. The subsequent symptoms for the first week or more were those of demorphinization.

Still another case was one who had been taking the crude opium by mouth for more than fifteen years. No crystals but a very marked anæmia.

In these four cases I have not been able to demonstrate these crystals and in most instances for obvious reasons.

Since in the five cases where there was a straight history of morphinism and patient at the time taking the drug when examination was made, all of these cases showed a peculiar crystalline formation, I have inferred that there must have been some chemical action between the blood of these morphino-maniacs and the Gower's solution, as when the blood was diluted with the ½% acetic acid sol., distilled water, hydrant water, undiluted blood, and smears stained and unstained I could not demonstrate them.

What would seem to make our present view tenable from a chemical point, that these crystals are due to the morphine taken into the system is the report of a very interesting experiment of Prof. J. G. Wormley of the University of Pennsylvania. (American Journal of Pharmacy in an article on "Some of the tests for Quinine.") In a case in which 1.68 grams (about 26 grs.) of strychnine were administered sub-cutaneously to a dog during a period of four hours, in divided doses, so as to keep the animal paralyzed, 56 mgs. of well crystallized strychnine were recovered from the urine, 26 mgs. from the liver, and 14 mgs. from the blood." He gives as his opinion that, "when morphine or strychnine is taken in excessive quantity, a portion seems to be distributed to the organs by simple exosmotic diffusion and this may be readily recovered in the crystalline state."

In the literature of blood examinations I have found no cases reported where these crystals were observed, and in a letter from Dr. Richard C. Cabot of Boston, the leading hæmotologist in the U. S., he tells me he has not met with them in his experience, neither has he seen them described in the literature on the subject.

In March 1897, through the interest taken in our observations on the blood of morphinomaniacs here by Dr. J. P. Sutherland, the Registrar of the B. U. S. M., there were undertaken a series of experiments under the supervision of Prof. Rockwell of the Department of Physiology; and to him and two of his students, Messrs. Walter S. Adams and T. C. Chandler, I wish to give full credit for the very painstaking experiments which have seemed to verify our observations here. The experiments were conducted over a period of five weeks. The following is the report presented from the Physiological Laboratory of Boston University:

"Twelve rabbits were taken for the experiment. Each rabbit was kept in a separate apartment, and an equal quantity of food was given to each one daily. To ten of the rabbits doses were given hypodermatically of sulphate of morphia twice each day. Commencing with a small amount and gradually increasing it at different rates for different rabbits. These ten were divided into five sets of two each, the same dose being given to each one of a set so that, if one should not live the work might not be interrupted. The other two of the twelve were kept normal for comparison with the others as a check on the work.

DOSAGE.

Date.	RABBITS. 1 & 2.	3 & 4.	5 & 6.	7 & 8.	9 & 10.	Date.	RABBITS. 1 & 2.	3 & 4.	5 & 6.	7 & 8.	9 & 10.
Mar.	Gr.	Gr.	Gr.	Gr.	Gr.	Mar.	Gr.	Gr.	Gr.	Gr.	Gr.
3, P. M.	1/8	1/8	1/8	1/8	1/8	22, P. M.	3/8	1/2	1	2 1/2	4 1/2
4, A. M.	1/8	1/8	1/8	1/8	1/8	23, A. M.	3/8	1/2	1	2 1/2	4 1/2
4, P. M.	1/8	1/8	1/8	1/4	1/4	23, P. M.	3/8	1/2	1	2 3/8	5
5, A. M.	1/8	1/8	1/8	1/4	1/4	24, A. M.	3/8	1/2	1	2 3/8	5
5, P. M.	1/8	1/8	1/8	3/8	1/2	24, P. M.	1/2	1/2	1 1/4	2 3/4	5 1/2
6, A. M.	1/8	1/8	1/4	3/8	1/2	25, A. M.	1/2	1/2	1 1/4	2 3/4	5 1/2
6, P. M.	1/8	1/4	1/4	1/2	3/4	25, P. M.	1/2	3/4	1 1/4	2 3/4	5 1/2
7, A. M.	1/8	1/8	1/4	1/2	3/4	26, A. M.	1/2	3/4	1 1/2	2 3/4	5 1/2
7, P. M.	1/8	1/4	1/4	3/8	1	26, P. M.	1/2	3/4	1 1/2	3	5 1/2
8, A. M.	1/8	1/4	1/4	3/8	1	27, A. M.	1/2	3/4	1 1/2	3	5 1/2
8, P. M.	1/8	1/4	1/4	1/2	1 1/2	27, P. M.	1/2	3/4	1 1/2	3 1/2	6
9, A. M.	1/8	1/4	1/4	1/2	1 1/2	28, A. M.	1/2	3/4	1 1/2	3 1/2	6
9, P. M.	1/8	1/4	1/2	1/2	1 1/2	28, P. M.	1/2	3/4	1 1/2	3 1/2	6 1/2
10, A. M.	1/8	1/4	1/2	1/2	1 1/2	29, A. M.	1/2	3/4	1 1/2	3 1/2	6 1/2
10, P. M.	1/4	1/4	1/2	1	1 3/4	29, P. M.	1/2	3/4	1 1/2	3 3/4	6 1/2
11, A. M.	1/4	1/4	1/2	1	1 3/4	30, A. M.	1/2	3/4	1 1/2	3 3/4	6 1/2
11, P. M.	1/4	1/4	1/2	1 1/4	2	30, P. M.	1/2	1	1 3/4	3 1/2	6 3/4
12, A. M.	1/4	1/4	1/2	1 1/4	2	31, A. M.	1/2	1	1 3/4	3 1/2	6 3/4
12, P. M.	1/4	1/4	1/2	1 1/4	2 1/4	31, P. M.	3/4	1	1 3/4	3 3/4	7
13, A. M.	1/4	1/4	1/2	1 1/2	2 1/4	Apr.					
13, P. M.	1/4	1/2	1/2	1 3/8	2 1/2	1, A. M.	3/4	1	1 3/4	3 3/4	7
14, A. M.	1/4	1/2	1/2	1 3/8	2 1/2	1, P. M.	3/4	1	1 3/4	3 3/4	7 1/4
14, P. M.	1/4	1/2	1/2	1 1/2	2 3/4	2, A. M.	3/4	1	1 3/4	3 3/4	7 1/4
15, A. M.	1/4	1/2	1/2	1 1/2	2 3/4	2, P. M.	3/4	1	2	3 3/4	7 1/2
15, P. M.	1/4	1/2	1/2	1 5/8	3	3, A. M.	3/4	1	2	3 3/4	7 1/2
16, A. M.	1/4	1/2	1/2	1 5/8	3	3, P. M.	3/4	1	2	4	7 3/4
16, P. M.	1/4	1/2	1/2	1 3/4	3 1/4	4, A. M.	3/4	1	2	4	7 3/4
17, A. M.	1/4	1/2	1/2	1 3/4	3 1/4	4, P. M.	3/4	1 1/4	2	4 1/4	8
17, P. M.	1/2	1/2	1/2	1 7/8	3 1/2	5, A. M.	3/4	1 1/4	2	4 1/4	8
18, A. M.	1/2	1/2	1/2	1 7/8	3 1/2	5, P. M.	3/4	1 1/2	2 1/4	4 1/2	8 1/4
18, P. M.	1/2	1/2	3/4	2	3 3/4	6, A. M.	3/4	1 1/2	2 1/4	4 1/2	8 1/4
19, A. M.	1/2	1/2	3/4	2	3 3/4	6, P. M.	3/4	1 1/2	2 1/4	4 3/4	8 1/2
19, P. M.	1/2	1/2	3/4	2 1/4	4	7, A. M.	3/4	1 1/2	2 1/4	4 3/4	8 1/2
20, A. M.	1/2	1/2	3/4	2 1/4	4	7, P. M.	1	1 1/2	2 1/4	4 1/2	8 1/2
20, P. M.	1/2	1/2	3/4	2 1/4	4 1/4	8, A. M.	1	1 1/2	2 1/4	4 1/2	8 1/2
21, A. M.	1/2	1/2	3/4	2 1/4	4 1/4	8, P. M.	1	1 1/2	2 1/2	4 3/4	8 1/2
21, P. M.	1/2	1/2	1	2 3/8	4 1/2	9, A. M.	1	1 1/2	2 1/2	4 3/4	8 1/2
22, A. M.	1/2	1/2	1	2 3/8	4 1/2	9, P. M.	1	1 1/2	2 1/2	4 3/4	8 1/2

WEIGHTS.

Rabbit No.	Mar. 3.		Mar. 10.		Mar. 17.		Mar. 24.		Mar. 31.		Apr. 7.	
	lbs.	oz.	lbs.	oz.	lbs.	oz.	lbs.	oz.	lbs.	oz.	lbs.	oz.
1	4	4 1/4	4	11 3/4	4	8	4	11	4	9 1/2	4	8
2	4	1	4	3 1/2	4	2 1/2	3	9 1/2	3	13 1/2	3	11 3/4
3	3	11	4	1 1/2	3	13 3/4	3	1/4	3	15	3	13 1/4
4	4	7	4	7 3/4	4	2 3/4	4	2 1/2	4	3/4	4	1
5	3	10 3/4	3	13	3	12 3/4	3	13 1/4	3	12 3/4	3	12 3/4
6	3	15 1/2	4	2 1/2	3	8 1/2	3	8 1/2	3	10 3/4	3	6 3/4
7	3	11 1/4	3	14	3	11 1/2	3	13 1/4	3	9	3	5 3/4
8	4	8 1/2	4	7 3/4	4	3 1/4	4	1 3/4	4	1/2	4	3
9	4	2 3/4	4	3/4	4	3/4	4	2 1/2	4	4 1/2	3	13 1/2
10	3	8 1/2	3	10 3/4	3	9 3/4	3	10	3	9 1/2	3	7 1/2
Checks 0	2	11 1/4	3	3/4	3	3	3	1 3/4	3	1 1/4	3	1/2
Checks 00	3	8 1/2	3	8 1/2	3	12 1/2	3	10 1/4	3	11 3/4	3	9

The doses were given one between 8 and 9 A. M., and the other between 5 and 6 P. M. Food was given just before the doses, consisting of turnips and carrots and averaging twelve ounces a day. Blood taken from the ear of the rabbits and diluted with Gower's solution 1-50 and 1-100 was examined microscopically from time to time. Nothing out of the ordinary was found until March 23d, (the end of the 3d week of the experiment), when in blood from No. 8 which was taking 2½ grs. per diem, and No. 9 which was taking five grs. per diem, small colorless crystals were found. These were cylindrical about 21 M long and 2 M wide. Later crystals of the same general character were found in rabbits numbers 5, 6, 7, 8, 9 and 10. Some of these crystals were large at one end, narrowing to a point at the other. The others were like those mentioned above. The largest one found was about 60 M long and 3.5 M wide. The blood from the check rabbits was also examined at frequent times during the experiment, but at no time were the crystals discovered.

"The general health of the animals was good throughout the experiment. After becoming accustomed to the new conditions the appetites seemed to increase and no other effect was noticed save a tendency to drowsiness soon after receiving the dose. Of course this was more marked in those taking the largest amounts of the drug, and here the usual symptoms of contracted pupil and slow pupillary reflexes were observed." You will see the close resemblance in the results of these experiments and the results of the examination of the five cases of morphinomaniacs above referred to. In three of the five pairs of rabbits they were able to demonstrate these crystals. The remaining two at no time were receiving more than 1½ grs. a day. In these they were not observed.

PATHOLOGY.

Dr. Norman Kerr in the XX Century Practice of Med. in his article on the opium habit, in discussing the action of opium claims that "it slightly raises the vital temperature. As opium diminishes arterial tension it may produce passive congestion of the kidneys and other organs." The production of a passive congestion I succeeded in demonstrating by autopsy on two of the rabbits used in the experiment above referred to. The rabbits selected were one taken from the pair taking the largest amount of the drug, and the other was one of the checks. Attention was directed particularly to the kidneys and liver. These organs in the check were in a normal condition, while in the other there was a passive congestion of both the kidneys and the liver.

One would naturally suppose that this passive congestion would naturally lead to the production of an albuminuria, and yet Dr. Kerr in his wide experience in London has never found albuminuria in morphinomaniacs except when albuminuria has preceded morphinism.

However, in a copy of the Indian Medical Record Dr. Artman reports two cases, taking each 240 grains per diem where albuminuria was present. In our five straight cases one only showed a trace of albumen with a few small hyaline casts, and the other four, one showed the presence of a few hyaline casts but no albumen. Whether these conditions existed before I do not know.

Dr. B. Sachs in Hamilton's System of Legal Medicine writes that "the condition produced by excessive use of morphine varies in different individuals. As a rule there is at first great irritability of temper, excessive restlessness, (allayed for a time by each fresh dose), lack of energy and application to work, a distinct loss of memory, which may lead to complete apathy and imbecility. Early in the career of the morphine fiend a general depravity is noticeable: he shows a disregard for truthfulness and will resort to any subterfuge, even to stealing to get the drug." The description given certainly coincides with the clinical experience of cases treated here.

The pathology of the temporary condition induced by the sudden withdrawal of morphine is well presented in an article by P. Sollier of Paris in La Semaine Medicale for Aug. 17, 1895. Of the effects of demorphinization upon the liver, he observes that "under the influence of morphia intoxication the functions of the liver are diminished; this is also the case with the other glands of the organism. After the suppression on the contrary, it presents a very great over activity, and diarrhœa, sometimes vomiting, occurs. During the first forty-eight hours the stools and material vomited consist almost exclusively of pure bile in large quantities." He was not able to demonstrate chemically the presence of morphine in these discharges, but inferred that in this way the system ridded itself of the stored up drug, and indeed so the clinical symptoms would seem to indicate. As to the vomiting of bile, and the passage of bile in the stools he draws a clinical picture which in the experience of the hospital is a classical description.

It is his opinion, and one I believe now generally accepted that, "the functional over activity of the liver and all of the glands, particularly those of the digestive tract, occasions an active organic regeneration, accompanied by cellular renovation." So that "the greater the evacuation of the bile, the more complete the renovation." It is, however, to be borne in mind that with this condition the tendency to relapse is greater because of the extreme delicacy of the regenerated organs which do not resist very strongly new intoxicants.

In conclusion we wish to emphasize that in the study of this class of cases too much can not be known of them. All clinical symptoms must be sought by the best methods of examination, and not the least among them is a thorough examination of the blood, demonstrate, if we can, these crystals. Truly they are not the sine qua non of the diagnosis of morphinism, but to those of us who are familiar

with the difficulty of treating morphinomaniacs know of their entire disregard for truth, their moral depravity, and the means they will resort to for procuring the drug; baffling at times all honest effort on the part of the physician, cannot fail to appreciate so simple a method of detecting the true state of affairs. I think it must be considered an advantage to know if the patient is taking morphine, no matter how small this advantage may be on the ultimate results of the case.

DISCUSSION.

Concerning paper, "A Phenomenon Observed in the blood of Morphinomaniacs," by Dr. S. C. Fuller, Dr. N. Emmons Paine said: — "We have known of this work that has been going on here for the last year and a half, and some hesitation has been felt by the Consulting Board of the Westboro Hospital in having it published and recognized. I want to congratulate Dr. Fuller in having done original work of that kind. I want to congratulate our society in hearing this for the first time. I hope Dr. Fuller will continue in this original work, as he has accomplished something no one else has ever done in the past year and a half. This society will always be ready to hear Dr. Fuller and we congratulate him on the original work so far accomplished."

Dr. Crisand: — "Did I understand the Dr. to say when the patient was taking 2 grains he could not demonstrate them?"

Dr. Fuller: — "When the patient was taking less than 3 grains I could not demonstrate them."

Of paper, "The Responsibility of Epileptics; A Case, E. L. Keith, M. D., Dr. Geo. S. Adams said: — "The point that comes to me as being most important is the question of marriage for epileptics. I am very much opposed to it. The question also arises as to the legality of a marriage contracted by an epileptic who concealed the epilepsy, and I believe such a marriage can be annulled if it can be proved that by reason of their epilepsy they were incapable of consenting to the marriage. I have had cases at this hospital where the husband or wife of the epileptic patient were not aware that they were epileptic until after marriage, and children have been born to such couples. Fortunately such marriages are not very prolific. Should the patient, whose history we have just heard, concealing the fact of her epilepsy, persuade the young man to marry her, I believe he, if he wished, could secure the annulment of the marriage."

BY-LAWS

OF THE

MASSACHUSETTS

HOMEOPATHIC MEDICAL SOCIETY,

AS IN FORCE, APRIL, 1899.

OBJECTS OF THE SOCIETY.

ARTICLE I. Since homeopathy aims at the improvement and reformation of the art of healing by aid of medicines, proved by every means that promises to enlarge the knowledge of the laws governing the action of drugs, this Society hereby declares its objects to be,—

The development of the materia medica by proving drugs upon the systems of men and animals; the administering of medicines thus proved, to the sick, in accordance with the formula *similia similibus curantur;* the encouragement of special studies and reports calculated to improve its members in the collateral branches of medicine.

ART. II. This Society demands for itself absolute liberty in science, and hence requires of its applicants for membership no creed or confession of medical belief, but only the expression of a willingness to act for the furtherance of its declared objects.

SOCIETY.

ART. III. This Society shall consist of the persons named in the Act of Incorporation, and such other persons as may have been elected members in accordance with its By-Laws.

OFFICERS OF THE SOCIETY AND THEIR ELECTION.

ART. IV. *Section 1.* — The Society at its annual meeting, shall elect by ballot a president, two vice-presidents, corresponding secretary, recording secretary, treasurer, librarian, and five censors, who shall together constitute an executive committee, to whom shall be intrusted the general business of the Society when it is not in session; the appointment of all standing committees and such other committees as they may deem expedient; the

appointment of a necrologist and auditor, and the selection of some suitable person, and substitute, to deliver an oration at the Semi-Annual Meeting of the Society, on some subject connected with medical science. At every Annual Meeting they shall present a report of their proceedings during the past year. They shall have power to remit the dues of worthy members who may produce satisfactory evidence that they are unable to pay. The officers shall continue in office till the adjournment of the Annual Meeting next after their election, at which time the duties of the newly elected officers shall commence.

Section 2. — Voting for officers of this Society shall be exclusively by ballots cast previous to the Annual Meeting. To this end the executive committee shall appoint a special election committee of three, none of whom shall be regular candidates for office, whose duty shall be to receive and count the ballots cast, and declare the results to the Society. Should any of this committee be absent at the opening of the Annual Meeting, the presiding officer shall fill such vacancies from the members present.

Section 3. — At least sixty days before the Annual Meeting the Secretary shall forward to all members in good standing, a preliminary notice informing them of the nominations for offices made by the nominating committee; and at a date not later than fourteen days before said meeting he shall also forward (with notice of meeting and a special addressed envelope) the official ballot containing all nominations by the nominating committee, and those by any special caucuses which may have convened for that purpose. The names of all candidates for each office shall be arranged upon the ballot in alphabetical order and, unless otherwise designated, shall be known as presented by the nominating committee. The names of all candidates for re-election shall be marked with an asterisk (*), while those nominated by a special caucus of members and certified to by at least ten members present, shall be marked with a dagger (†). If any candidate decline his nomination previous to the printing of the ballot it shall be so designated thereon.

Section 4. — All nominations by special caucus must be in the hands of the Secretary at least thirty days before the annual meeting.

Section 5.—Members shall prepare their ballots by making the sign X against the names of the candidates for whom they wish to vote. If in any instance more names are thus marked than there

are officers to be elected, no name for such office shall be counted. This shall not, however, invalidate the ballot for the other officers.

Section 6. — All members desiring to vote must return their ballots in the "official return envelope" to the Secretary, so that they shall be received by him not later than the midnight before the annual meeting, and on the morning of said meeting he shall deliver them unopened to the special election committee for official inspection and count.

Section 7.—Candidates receiving the highest number of votes shall be declared elected.

DUTIES OF THE OFFICERS.

ART. V. The President shall preside at all meetings of the Society and of the Executive Committee, and shall deliver an address before the Society at the Annual Meeting.

In case of the absence or other disability of the President, his duties shall devolve on the Vice-President by seniority, if present. And for that purpose the person receiving the largest number of ballots for that office, shall hold the seniority. Otherwise, on such member as the presiding officer shall appoint, or the meeting may select.

ART. VI. The Corresponding Secretary shall have the charge and custody of all letters and communications transmitted to the Society; and to him they should be addressed. He shall prepare and transmit whatever communications the Society or Executive Committee may direct, and he shall perform such other duties as may be assigned to him.

ART. VII. The Recording Secretary shall give notice and keep a record of all the meetings of the Society and of the Executive Committee. He shall insert in the notices of the Annual and Semi-Annual Meetings the names of those candidates for membership that have been reported to the Executive Committee. He shall have charge of all papers and communications belonging to the Society, and shall read at the meetings of the Society all such communications as the Executive Committee may direct. He shall notify the chairman of every committee appointed by the Society or Executive Committee, of his appointment, in each case stating the commission and the names of the committee. On or before the first of April, annually, he shall transmit to the Treas-

urer a list of all who have become members of the Society during the year.

The Recording Secretary shall receive fifty dollars annually as a compensation for the labors and duties incumbent upon the office.

ART. VIII. The Treasurer shall solicit and receive all money due to the Society, together with all bequests and donations, and shall pay all bills after they shall have been approved by the Executive Committee, which approval shall be certified to by the Recording Secretary. He shall keep an accurate account of all receipts and expenditures, and shall give such bonds for the faithful performance of his duties as the Society may require. He shall submit his accounts to the auditor at least once each year, and shall annually make a statement of his doings, and of the state of the funds in his hands, to the Society.

The Treasurer shall receive fifty dollars annually as a compensation for his services.

ART. IX. The Librarian shall have in his custody and charge all the books and apparatus of the Society. He shall keep an accurate register of the same, and arrange them in a proper manner, and shall make such disposition of them, from time to time, as the Executive Committee may direct, for the benefit of the members. He shall receive and record all donations made in his department to the Society, and shall make a report at the Annual Meeting.

ART. X. The Censors shall examine the qualifications of all persons presenting themselves for membership, and for that purpose shall hold meetings on the same days as the regular meetings of the Executive Committee, and at such other times as they may deem necessary. They shall verify the medical diplomas of all applicants for membership, and report the names of all approved candidates for membership to the Executive Committee at least three months before their election as members of the Society.

ART. XI. There shall be a Committee on the Materia Medica, who shall select remedies for proving, and shall, at the expense of the Society, obtain and distribute the same to its members, or such other persons as they may deem suitable. They shall receive and examine communications upon the materia medica from the members of the Society, and report thereon at any regular meeting.

ART. XII. There shall be appointed annually, by the Executive Committee, a Committee on Nominations composed of the

President, ex officio, and four Society members at large, whose duty shall be to nominate two candidates for each of the twelve offices named in Art. IV., Section I, and file a certified copy of the same with the Recording Secretary, at least sixty days before the Annual Meeting.

ART. XIII. There shall be a Committee of Publication, consisting of the President, Recording Secretary, and at least three other members, to whom all matter for publication shall be referred, and under whose direction it shall be issued; the expense of which shall not exceed in any year a sum designated by the Executive Committee.

ART. XIV. There shall be a Committee of Arrangements, whose duty it shall be to make such arrangements as will add to the interest and importance of the Annual and Semi-Annual meetings, such as selecting a suitable place for the meetings, soliciting communications, appointing subjects for discussion, providing refreshments for members, etc., subject to the direction of the Executive Committee.

ART. XV. The Executive and all other committees shall have power to fill their own vacancies.

MEMBERSHIP.

ART. XVI. Any person who has received the degree of doctor of medicine from a legally authorized medical institution, and who sustains a good moral character, may become eligible to membership after having been examined and approved by the Board of Censors. He shall be elected by ballot at the Annual or Semi-Annual Meeting, and his having signed the application for membership shall be considered equivalent to an agreement to abide by the By-Laws. In case that ten negative ballots shall be cast, the name of the candidate shall be referred back to the Board of Censors, who shall make a thorough investigation, and report to the Executive Committee.

The same conditions of membership shall also apply to women having like qualifications.

All members in good standing who shall have paid their annual dues for twenty-five years, consecutive or otherwise, shall attain the rank or title of life-members, and shall be entitled to all the privileges of the Society, but shall be exempt from the payment of the annual assessment.

HONORARY AND CORRESPONDING MEMBERS.

ART. XVII. Persons who have excelled, or made any great advancement in medical or other science, may be elected honorary members; and physicians of eminence residing out of the State may be elected corresponding members of the Society by a two-thirds vote of the members present at any stated meeting, provided the said person shall have been approved by the Executive Committee. Honorary and corresponding members shall be entitled to the diploma of the Society, and to participate in its proceedings in meetings devoted to scientific subjects.

ART. XVIII. Every applicant for membership shall deposit with his application in the hands of the Recording Secretary, the sum of five dollars, and shall, upon his election, receive therefor the diploma of the Society, signed by the President and Secretary. Should an applicant fail of election, the money shall be returned to him.

ART. XIX. Any member in good standing shall have the privilege of withdrawing from the Society by giving notice, in writing, of such intention, and paying all arrearages due to the Society.

RETIRED MEMBERS.

ART. XX. Members, on removing from the State, or on retiring from practice, may, provided all their dues to the Society are paid, by a vote of the Executive Committee, be placed on the list of retired members, and, as such, shall be exempt from any assessments, and shall not receive, except by courtesy, any of the publications of the Society, nor be entitled to speak or vote at any of its meetings.

ART. XXI. Any person who has resigned his membership, or been placed on the list of retired members, may, on application in writing, be reinstated by a vote of the Society at any regular meeting.

Any member removing out of the State shall have liberty to retain his membership on paying his annual assessment.

EXPULSION AND DISCIPLINE.

ART. XXII. Any member may be expelled from the Society, or, having resigned his membership, may be deprived of his privileges by a vote of two-thirds of the members present at any regular meeting, upon charges of the following description, provided the

charge or charges against him have first been considered by the Executive Committee, and provided he has been notified of the same by the Secretary, and an opportunity has thereby been given him to make his defense before the Society: —

1. For any gross and notorious immorality or infamous crime under the laws of the land.

2. For any attempt to subvert the objects, or injure the reputation of the Society.

3. For advertising, publicly vending, or pretending to the knowledge and use of any secret nostrum.

4. For advertising one's self, or knowingly allowing one's self to be advertised as possessing extraordinary powers or ability.

5. For any conduct which, in the opinion of two-thirds of the members present at a regular meeting, shall be dishonorable.

ART. XXIII. As the object of the Society is to improve the science of medicine, to increase the usefulness and influence of its members, and to secure greater harmony and friendship among them, therefore it is of the highest importance that each member should so conduct himself, both in his private and professional life, as to command the entire respect of his colleagues.

Every person who becomes a member is understood to take upon himself an obligation to communicate to the Society any discoveries he shall have made relating to the science of medicine or surgery, and to co-operate in such measures as may be adopted by the Society for the advancement of these sciences; and, on his refusal to do so, he shall be subject to such censure as the Society, by a two-thirds vote of the members present at a regular meeting, shall inflict.

DUES.

ART. XXIV. Every member of the Society, the Recording Secretary, Corresponding Secretary, Treasurer, and life members excepted, shall be assessed annually five dollars, and such other assessments as a majority of the members, at any legal meeting, may determine. Newly elected members shall not be liable to assessment during the year of their election.

DELEGATES.

ART. XXV. The Executive Committee may appoint delegates to other societies and associations whenever they may deem it advisable to do so; and such delegates shall receive certificates of appointment from the Recording Secretary.

Accredited delegates from other societies and associations shall be allowed to participate in the scientific deliberations of this Society.

MEETINGS OF THE SOCIETY.

ART. XXVI. The Annual Meeting of the Society shall be held on the second Wednesday of April, and the Semi-Annual Meeting on the second Wednesday of October, at 10 o'clock A. M., in such one of the cities or towns of the Commonwealth as the Executive Committee may determine. A special meeting of the Society shall be called by the President, on the written request of ten members, stating the object of such meeting. At all regular meetings of the Society thirty members shall constitute a quorum for the transaction of business.

ART. XXVII. The Executive Committee shall meet on the third Wednesday of April, July, October and January. At the first or Annual Meeting, the committees, the Orator, substitute Orator, Necrologist and Auditor shall be appointed for the ensuing year.

At the meetings of the Executive Committee, five persons shall constitute a quorum. A special meeting of the Executive Committee shall be called by the president, on the written application of three of its members.

ALTERATION OF BY-LAWS.

ART. XXVIII. All proposals for alteration of the By-Laws shall be presented to the Society in writing, at a regular meeting; and shall be referred without debate, to a special committee of five, who shall consider and report on the same to the Recording Secretary, at least thirty days before the Annual Meeting. He shall mail a printed copy of such report to each of the members with the programme of the Annual Meeting.

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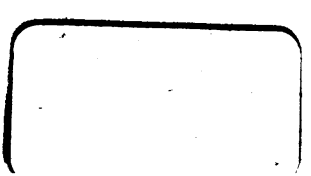
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